CCME

2019 External Quality Review

BLUECHOICE HEALTHPLAN OF SC

Submitted: June 13, 2019

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the *2019 External Quality Review (EQR)* The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by BlueChoice HealthPlan (BlueChoice) since the 2018 Annual Review.

The goals of the review are to:

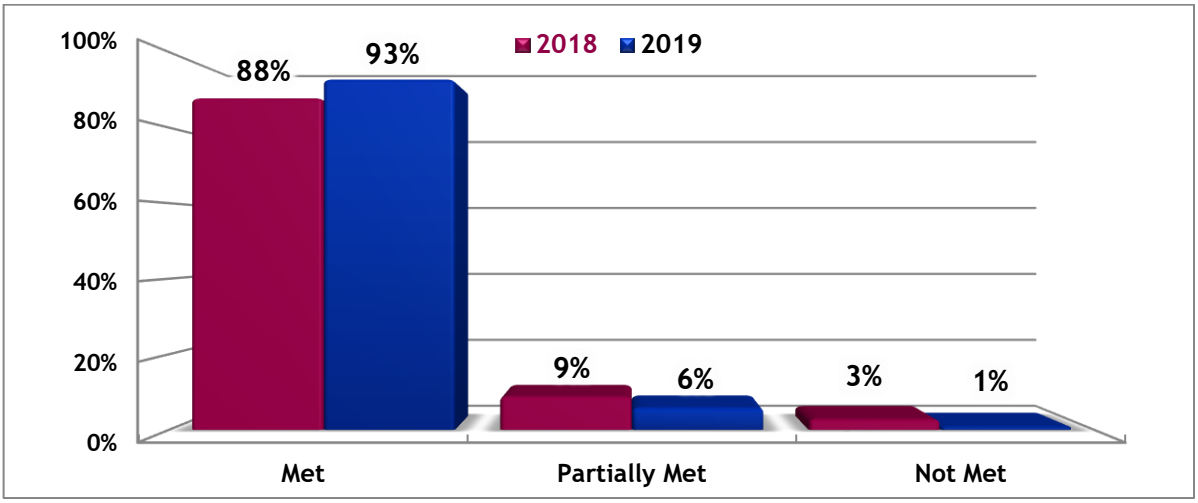
- Determine if BlueChoice is following service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2018 Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

The process CCME used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day onsite visit, a *Telephonic Provider Access Study*, compliance review, validation of performance improvement projects (PIPs), validation of performance improvement measures, and validation of satisfaction surveys.

Overall Findings

The 2019 annual EQR shows that BlueChoice has achieved a "Met" score for 93% of the standards reviewed. As the following chart indicates, 6% of the standards were scored as "Partially Met," and 1% of the standards scored as "Not Met." The chart that follows provides a comparison of BlueChoice's current review results to the 2018 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items and recommendations can be found further in the narrative of this report.

Administration:

BlueChoice partners with Amerigroup Partnership Plan, LLC (Amerigroup) to support its Medicaid line of business. Contractually required positions are filled and staffing is adequate to conduct all required activities. The Director, Quality Management is not currently located in SC but plans to relocate within the next two months. The board-certified psychiatrist is not licensed in SC but is in the process of obtaining SC licensure.

BlueChoice's personnel and systems have a demonstrated ability to perform Medicaid processing required by SCDHHS. A strong focus is placed on safeguarding facilities and systems that house Medicaid data; incident response and recovery is a priority.

BlueChoice submitted comprehensive documentation that describes activities and processes used to prevent, detect, and respond to suspected and actual violations of ethical conduct standards and fraud, waste, and abuse (FWA). BlueChoice uses appropriate processes to communicate Compliance standards, policies and procedures, and for initial and ongoing Compliance training for employees and network providers, etc. Internal monitoring and assessments are conducted to identify and respond to any Compliance issues. BlueChoice maintains an "open door" environment and provides suitable forums for confidential and anonymous reporting of Compliance and FWA issues or concerns.

Provider Services:

The Medical Director, Dr. Lloyd Kapp, chairs the Credentialing Committee. Additional committee members include the Vice President of Medical Affairs and nine network providers. The specialties represented include internal medicine, pediatrics, chiropractic, surgery, pulmonology, OB/GYN, dental, nurse practitioner, and certified family nurse practitioner. A review of committee minutes showed the quorum of at least three external voting members was met.

BlueChoice conducts the credentialing process for behavioral health providers; however, the Companion Benefit Alternatives (CBA) Credentialing Committee conducts credentialing approval activities related to behavioral health.

The *Healthy Blue Credentialing Program Plan* gives an overview of the credentialing program, and several policies address the processes for initial credentialing and recredentialing. While the program and policies are comprehensive, they do not address each query required by SCDHHS Program Integrity such as the Suspended List and the Behavioral Health Actions List. Overall, the credentialing and recredentialing file review showed appropriate documentation except for proof of queries for the Suspended List and the Behavioral Health Actions List.

BlueChoice has a solid network with availability exceeding contractual requirements. In 2018 BlueChoice conducted a physician office appointment access survey; however, only three provider groups of 471 responded, which did not provide reliable data. BlueChoice is considering hiring a company to perform future surveys per onsite discussion.

CCME conducted a *Telephonic Provider Access Study* and calls were successfully answered 57% of the time (147 of 260) when omitting 33 calls answered by voicemail messaging services. For calls not answered successfully (n=113 calls), 56 (50%) were unsuccessful because the provider was not at the office or phone number listed. When compared to results of 69% from 2018, the decrease in successful answer rate was statistically significant.

Member Services:

BlueChoice has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. Information is included in the *Evidence of Coverage*, *Provider Manual*, on BlueChoice's website, and in member newsletters.

The *Evidence of Coverage* provides a list of preventive health guidelines and refers members to the website to view the detailed guidelines. BlueChoice encourages members

to obtain recommended preventive services, including well-child services, via the website, the *Evidence of Coverage* and through mailings.

Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff. CCME identified uncorrected deficiencies from the previous EQR. These include discrepancies in documentation of the grievance record retention practices and the timeframe in which grievances are resolved.

Quality Improvement:

BlueChoice's *2019 Medicaid Quality Management Program Description* describes the program's quality improvement (QI) structure, function, scope, and goals as defined by the health plan. BlueChoice's Medicaid Board of Directors has ultimate authority and accountability for the QI Program. This Board of Directors has delegated the responsibility for development and implementation to the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC). Both committees are responsible for monitoring and evaluating the results of quality initiatives and initiating improvement projects when areas needing improvement are identified.

BlueChoice provided the *2018 Quality Management Program Work Plan Annual Evaluation* for CCME's review. Because this program evaluation was a draft, neither the SQIC nor the CQIC reviewed or approved it. Staff indicated they were in the process of completing the evaluation and will submit the document to the committees. There appeared to be sections of the document that contained incorrect or incomplete information.

The performance measures and performance improvement projects (PIPs) met the CMS validation requirements. The comparison from the 2016 measurement year to the 2017 measurement year revealed a substantial improvement (>10%) in Immunizations for Adolescents – HPV, Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence for 13-17 year-olds, Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5 year-olds, and Psychosocial Care for Children and Adolescents on Antipsychotics for 12-17 year-olds and the overall Total Rate. The measures that decreased were Diabetes Monitoring for People With Diabetes and Schizophrenia and Pharmacotherapy Management of COPD Exacerbation -Systemic Corticosteroid. *Table 1: HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from 2016 to 2017.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	Change from 2016 to 2017
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescence			
HPV	14.58%	25.06%	10.48%
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	58.89%	71.91%	13.02%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence			
13-17 Years	5.26%	21.21%	15.95%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	11.11%	57.14%	46.03%*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
12-17 Years	24.59%	55.56%	30.97%
Total	35.35%	53.01%	17.66%
Substantial Decrease in Rate (>10% decrease)			
Diabetes Monitoring for People With Diabetes and Schizophrenia	65.38%	51.35%	-11.45%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	63.86%	51.19%	-12.67%

BlueChoice reported 12 quality clinical withhold measures for 2017. Per the *SCDHHS Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by individual measure weights then summed to obtain the quality index score. The 2017 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Pediatric Preventive Care rates generated the highest index score, followed by Women's Health, and then Diabetes.

Table 2: Quality Withhold Measures

Measure	2017 Rate	2017 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	84.91%	25	3	3.2
HbA1c Control (< =9)	48.18%	25	3	
Eye Exam (Retinal) Performed	42.82%	25	3	
Medical Attention for Nephropathy	91.73%	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	91.09%	90	6	4.2
Breast Cancer Screen	51.86%	25	3	
Cervical Cancer Screen	58.15%	25	3	
Chlamydia Screen in Women (Total)	54.72%	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	74.17%	90	6	4.3
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.23%	25	3	
Adolescent Well-Care Visits	48.66%	50	4	
Weight Assessment/Adolescents: BMI % Total	76.40%	50	4	

BlueChoice submitted three projects. They included Access and Availability of Care, Childhood Immunizations Combo 3 and Lead Screenings, and Comprehensive Diabetes Care. The Childhood Immunizations Combo 3 and Lead Screenings project was noted as retired, and the Comprehensive Diabetes Care project was new. The documentation received for the Comprehensive Diabetes Care PIP was missing data. This was discussed during the onsite, and BlueChoice provided a brief summary of the results and analysis. CCME used the PIP report and the brief summary to conduct its validation.

Interventions were initiated in 2017 for the Access and Availability of Care PIP and the results section was revised to align with benchmark and goal rates. However, the rates for this PIP continue to decrease instead of increase. During onsite, new interventions were discussed including home visits, enhanced Interactive Voice Response (IVR) calls, and the automated texting campaign.

Both projects received a score within the "High Confidence in Reported Results" level. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 3: Performance Improvement Project Validation Scores

PROJECT	2018 VALIDATION SCORE	2019 VALIDATION SCORE
Access and Availability of Care	83% Confidence in Reported Results	99% High Confidence in Reported Results
Childhood Immunizations Combo 3 and Lead Screenings	83% Confidence in Reported Results	Retired, Not Validated
Comprehensive Diabetes Care	Not Validated	100% High Confidence in Reported Results

Utilization Management:

BlueChoice partners with Amerigroup to administer the utilization management activities for its Medicaid line of business. The *Utilization Management (UM) Program Description* and policies provide guidance to staff conducting UM activities. A few issues were identified in documentation of UM requirements related to UM determination timeliness and information about extensions of authorization timeframes.

BlueChoice's Gold Card Program rewards a specific subset of providers who follow medically necessary criteria and who provide appropriate, high quality service. Program eligibility criteria are evaluated annually and providers who have achieved Gold Card status are audited annually to determine continued eligibility for the program.

BlueChoice implemented processes for the application of medical necessity criteria to ensure that individual member circumstances and the availability of services within the local delivery system are considered. BlueChoice assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing of both physician and non-physician reviewers.

CCME identified issues within the documentation of appeals handling and resolution processes including use of outdated terminology and incomplete definitions of appeal terminology, errors in appeal filing and resolution timeframes, and incomplete information regarding continuation of benefits. Appeal files, however, indicate staff

follow appropriate processes in the handling and resolution of appeals. Appeal data is tracked, trended, and reported to appropriate committees.

Case management (CM), care coordination, and care transitions processes are described in various program descriptions and associated policies. CM files reflected appropriate assessment, monitoring, care plan development and revision, referrals and teaching to address barriers, and interventions to progress toward goals. BlueChoice evaluates member satisfaction with the CM Program through a telephonic member satisfaction survey process conducted by an external vendor. From February 2018 to February 2019, satisfaction rates ranged from 91% to 95%.

Delegation:

BlueChoice's policies and processes address delegated activities. Each delegate has a written agreement or contract in place. While the plan may delegate certain functions, it maintains responsibility and accountability for oversight of delegated activities, including pre-delegation activities, ongoing monitoring, evaluation, and actions to improve identified opportunities.

Evidence of annual oversight conducted within the last year was provided for all delegated entities. While the oversight reports were comprehensive and contained appropriate information, the credentialing and recredentialing oversight file review tool did not contain all queries required by SCDHHS Program Integrity. Missing queries include the Suspended List and the Behavioral Health Actions List.

State Mandated Services:

Provider compliance with providing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through member medical record documentation reviews and Healthcare Effectiveness Data and Information Set (HEDIS) reports of Well-Child Visits. BlueChoice provides all core benefits the *SCDHHS Contract* specifies.

One standard was scored as "Not Met" due to uncorrected deficiencies from the previous EQR.

Table 4, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2018 review.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2018	38	0	1	0	0	39
2019	39	1	0	0	0	40
Provider Services						
2018	66	10	2	0	0	78
2019	72	5	1	0	0	78
Member Services						
2018	28	4	1	0	0	33
2019	31	2	0	0	0	33
Quality Improvement						
2018	13	2	0	0	0	15
2019	15	0	0	0	0	15
Utilization						
2018	42	2	1	0	0	45
2019	41	4	0	0	0	45
Delegation						
2018	1	1	0	0	0	2
2019	1	1	0	0	0	2
State Mandated Services						
2018	3	0	1	0	0	4
2019	3	0	1	0	0	4

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On March 18, 2019, CCME sent notification to BlueChoice that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow BlueChoice to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from BlueChoice on April 1, 2019 and reviewed in CCME's offices (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on May 16, 2019 and May 17, 2019 at BlueChoice's office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with BlueChoice's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the Contract requirements between BlueChoice and SCDHHS. Strengths, weaknesses and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

The Administration section of the External Quality Review (EQR) focuses on policies and procedures, staffing, information systems, compliance, program integrity, and confidentiality.

BlueChoice HealthPlan of South Carolina (BlueChoice) is part of the Blue Cross and Blue Shield Association and partners with Amerigroup Partnership Plan, LLC (Amerigroup) to support the administration of its Medicaid line of business. CCME's review of staffing confirmed contractually required positions are filled; however, the Director, Quality Management is not currently located in South Carolina (SC) and the board-certified psychiatrist is not licensed in SC. Both are required by the *SCDHHS Contract, Exhibit 1*. It was reported that the Director, Quality Management is planning to relocate to SC soon, and in the interim she spends approximately one week per month in SC and maintains close contact with staff when not in the state. Additionally, it was reported that the board-certified psychiatrist is in the process of obtaining SC licensure.

BlueChoice's Information Systems Capabilities Assessment (ISCA) documentation demonstrates the organization's personnel and systems have the capabilities to perform Medicaid processing SCDHHS requires. Specifically, BlueChoice's capabilities include a strong focus on safeguarding the facilities and systems that house Medicaid data. Business continuity plans provided indicate the organization places a priority on incident response and recovery.

The *Healthy Blue by BlueChoice Health Plan of South Carolina Compliance Plan (Compliance Plan)* and the *Anthem Special Investigations Unit Antifraud Plan (Antifraud Plan)* comprehensively describe activities and processes used to prevent, detect, and respond to suspected and actual violations of ethical conduct standards and suspected or actual fraud, waste, and abuse (FWA). Standards and expectations for ethical business conduct expected of all management, employees, subcontractors, etc. are detailed in the *Our Values* document which serves as a code of conduct.

Appropriate processes are in place for initial and ongoing Compliance training for employees, network providers, etc. and are described in the *Compliance Plan* and related policies. Compliance standards, policies, and procedures are communicated to staff through various forums and BlueChoice operates under an "open door" environment for Compliance questions or concerns. Methods are in place to allow confidential and anonymous reporting of issues or concerns. BlueChoice conducts internal monitoring and assessments to identify and respond to any Compliance issues. The Compliance Committee meets contractual requirements.

The *Antifraud Plan* and related policies define activities to prevent and detect FWA and describe investigative processes conducted in response to alleged or suspected FWA. Processes for monitoring the exclusion status of subcontractors, persons with an ownership or control interest, or who are agents or managing employees of the health plan are incompletely documented in the *Compliance Plan* and in a related policy. CCME discussed this during the onsite visit and was reassured by plan staff that appropriate surveillance is conducted to ensure staff and other applicable persons are not excluded.

As illustrated in *Figure 2, Administration Findings*, BlueChoice received "Met" scores for 97.5% of the standards in the Administration section.

Figure 2: Administration Findings

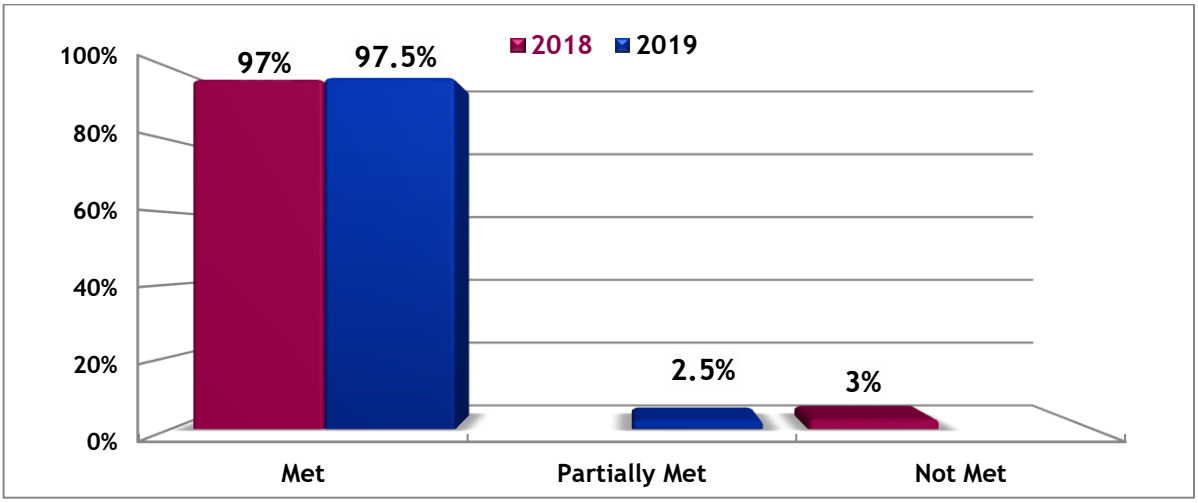


Table 5: Administration Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Compliance/ Program Integrity	The MCO has an established committee responsible for oversight of the Compliance Program	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Only one vacancy was noted on the Organizational Chart and staff report an offer has been extended to fill the position.
- The Organizational Chart was revised and color-coded to indicate whether staff are BlueChoice or Amerigroup employees.
- BlueChoice has thorough business continuity plans, a focus on system and physical access security, and follows best practices for access control.

Weaknesses

- The Director, Quality Management is not currently located in SC as the *SCDHHS Contract*, *Exhibit 1* requires, but is planning to relocate to the state and estimates this will occur by June 2019.

- Although BlueChoice has a board-certified psychiatrist on staff, he is not currently licensed in SC as the *SCDHHS Contract, Exhibit 1* requires. Staff report he is in the process of obtaining SC licensure.
- The Program Integrity Coordinator position is not designated and identified in the *Compliance Plan* or in the *Antifraud Plan*, as the *SCDHHS Contract, Section 11.2.2.2* requires.
- Page 8 of the *Compliance Plan* indicates BlueChoice conducts initial and monthly monitoring of federal and state exclusion databases, but it does not specify the federal databases monitored, nor does it address the required checks of the SCDHHS Program Integrity website. Missing items include the Social Security Administration's Death Master File (SSDMF), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and the SCDHHS Program Integrity databases (SC List of Excluded Providers, SC List of Providers Terminated for Cause, Suspensions List, and Behavioral Health Actions List).
- *Policy EP302, OIG/GSA Screening*, an Anthem Corporate policy, does not address all requirements specific to SC exclusion status monitoring—it does not address the requirement to query the SSDMF and the requirement to monitor the SCDHHS Program Integrity databases (SC List of Excluded Providers, SC List of Providers Terminated for Cause, Suspensions List, and Behavioral Health Actions List).
- The Compliance Committee's membership is documented in the *Compliance Committee Charter*, the 2019 *Quality Management Program Description*, and in the *Healthy Blue Committee List*. However, the *Healthy Blue Committee List* for the Medicaid Compliance Committee includes one member (Growth Director Medicaid Alliance) who is not included in the other documents. Onsite discussion confirmed the Growth Director Medicaid Alliance is not a member of the Compliance Committee.

Quality Improvement Plans

- Update the *Antifraud Plan* or *Compliance Plan* to include information about the roles and responsibilities of the Program Integrity Coordinator.
- Update the *Compliance Plan* and *Policy EP302* to include all queries required for exclusion status monitoring for SC. This can be accomplished via an addendum to the respective document.

Recommendations

- Ensure the Quality Management Director position is an in-state position as the *SCDHHS Contract, Exhibit 1* requires.
- Ensure the board certified psychiatrist or psychologist is licensed in the State of South Carolina as the *SCDHHS Contract, Exhibit 1* requires.

- Revise the Compliance Committee's membership in the *Healthy Blue Committee List* to reflect current membership of the committee.

B. Provider Services

CCME conducted a review of all policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines for Provider Services.

The Credentialing Committee has the responsibility for direction of the credentialing program and activities for credentialing potential network providers and facilities. The committee is chaired by Dr. Lloyd Kapp, Medical Director, with additional members including the Vice President of Medical Affairs and nine network providers. The specialties represented include internal medicine, pediatrics, chiropractic, surgery, pulmonology, OB/GYN, dental, nurse practitioner, and certified family nurse practitioner. Only the external committee members have voting privileges and at least three external voting committee members must be represented to constitute a quorum. A review of committee minutes showed the quorum was met.

The credentialing process for behavioral health providers is conducted by BlueChoice; however, the Companion Benefit Alternatives (CBA) Credentialing Committee conducts credentialing approval activities related to behavioral health.

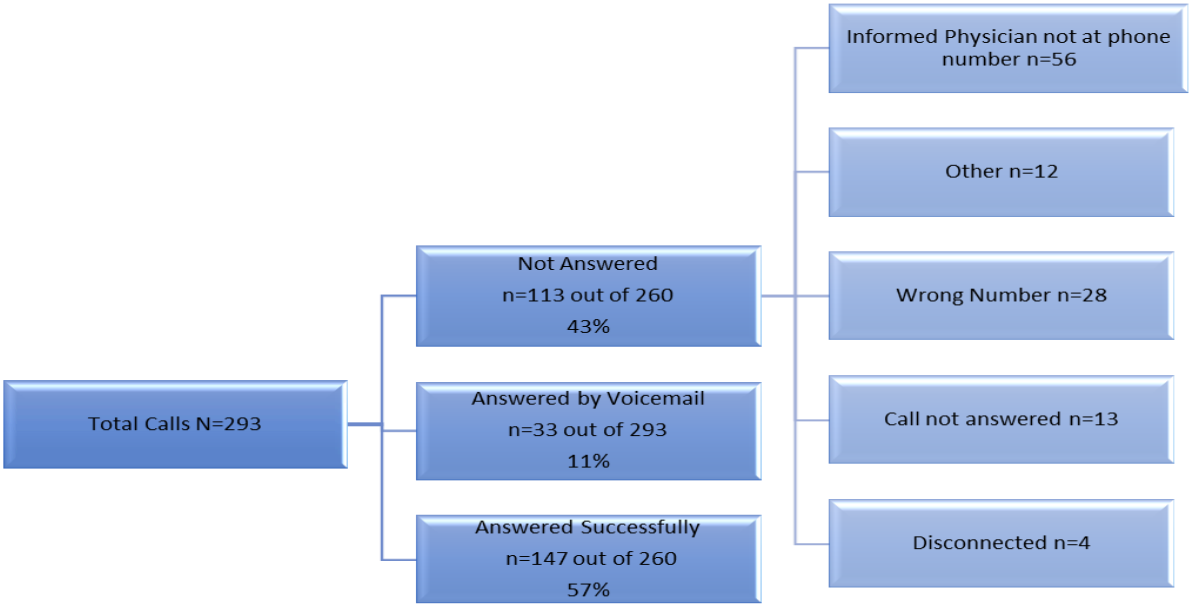
The *Healthy Blue Credentialing Program Plan* gives an overview of the credentialing program and several policies address the processes for initial credentialing and recredentialing. While the program and policies are comprehensive, they do not address each query SCDHHS Program Integrity requires, such as the Suspended List and the Behavioral Health Actions List. Overall, the credentialing and recredentialing file review showed appropriate documentation except for proof of queries for the Suspended List and the Behavioral Health Actions List.

Policies define provider availability and accessibility standards, and BlueChoice runs GeoAccess reports quarterly to assess network availability. BlueChoice has a solid network with availability exceeding contract requirements. Provider accessibility is measured through evaluating results of *Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* questions relating to complaints/grievances and provider access, conducting an after-hours survey, and a BlueChoice-conducted physician office appointment access survey in 2018. The physician office appointment access survey measured adherence to routine and urgent appointment standards and wait time for emergency care. A total of 471 provider groups were selected and postcards were mailed with instructions to complete an online survey. Only three provider groups responded, which did not provide reliable data. BlueChoice is considering hiring a company to perform future surveys per onsite discussion.

Provider Access and Availability Study

As part of the annual EQR process for BlueChoice, CCME conducted a *Telephonic Provider Access Study* focused on primary care providers (PCPs). The *BlueChoice Provider File* contained a population of 3,182 PCPs. From that, a random sample of 293 PCPs was selected for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only providers located in SC and documented as accepting new patients were selected for the sample. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the contracted providers. Calls were successfully answered 57% of the time (147 of 260) when omitting 33 calls answered by voicemail messaging services. For calls not answered successfully (n=113 calls), 56 (50%) were unsuccessful because the provider was not at the office or phone number listed. *Figure 3: Telephonic Provider Access Study Results* provides an overview of the successfully and unsuccessfully answered calls.

Figure 3: Telephonic Provider Access Study Results



When compared to results of 69% from 2018, the decrease in successful answer rate was statistically significant (p=.004) as shown in *Table 6: Telephone Access Study Answer Rate Comparison*.

Table 6: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2018 Review	309	69%	.004
2019 Review	293*	57%	

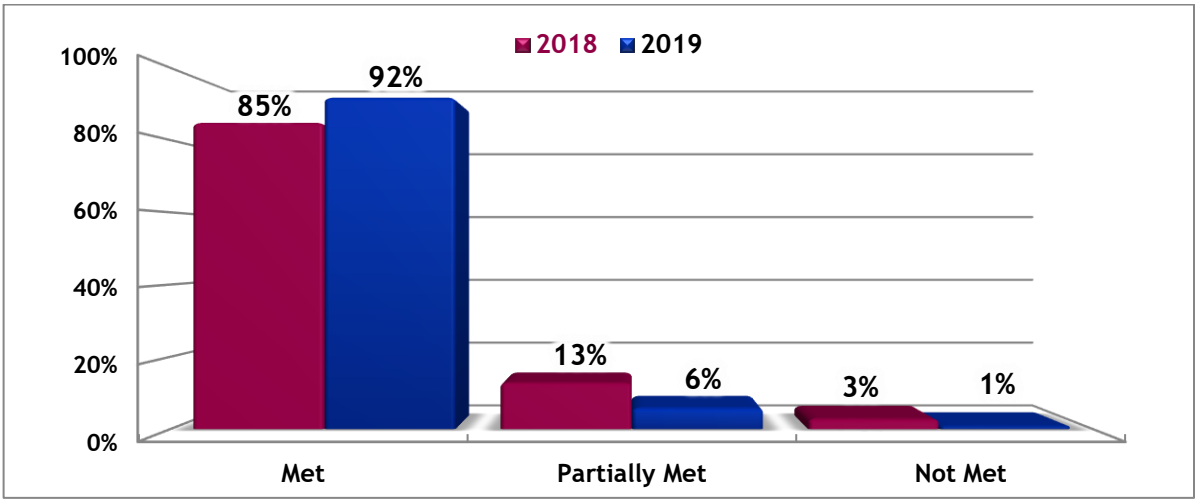
*denominator for answer rate was 260 to account for voicemail answering services for 33 calls

One hundred and twenty-five (86%) of the providers indicated they accept BlueChoice, and eight (5%) indicated this occurs only under certain conditions. Ninety-six of 130 (74%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 34 (37%) of the 92 providers that responded to the item indicated an application or prescreen was necessary. Of those 34, 17 (50%) indicated an application must be filled out, whereas six (19%) require a review of medical records/immunizations before accepting a new patient, and six (19%) required both. When the office was asked about the next available routine appointment, 62 of the 70 that responded (89%) met contact requirements.

Figure 4: Provider Services Findings shows that 92% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 7: Provider Services Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Credentialing and Recredentialing	Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list and the CMS Adverse Action Report List	Not Met	Partially Met
	Credentialing: Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Not Met	Partially Met
	Recredentialing: Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
Adequacy of the Provider Network	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met
Primary and Secondary Preventive Health Guidelines	The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Partially Met	Met
	The preventive health guidelines include, at a minimum, the following if relevant to member demographics: Behavioral Health Services	Partially Met	Met
Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services	The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Partially Met	Met

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Practitioner Medical Records	Standards for acceptable documentation in member medical records are consistent with contract requirements	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Participating network providers are well-represented in the Credentialing Committee membership.
- The *Provider Manual* is detailed and contains a wealth of information for providers to navigate the plan.

Weaknesses

- The *Healthy Blue Credentialing Program Plan*, Sections VI A, VI B, and VII do not include the Suspended List or Behavioral Health Actions list as required queries.
- *Policy MCD-04, Initial Credentialing* does not include the Suspended List or Behavioral Health Actions list as required queries.
- *Page 6 of Policy MCD-04* references *Policy MCD-02, Medical Office Pre-Contracting Site Review* which is no longer an active policy.
- *Policy MCD-05, Recredentialing* does not include the Suspended List or Behavioral Health Actions list as required queries.
- The credentialing and recredentialing files reviewed do not contain proof of query of the Suspended List or the Behavioral Health Actions List.
- The "Queries Performed" section of *Policy MCD-06, Health Care Delivery Organizations – Credentialing/Recredentialing* does not address each query SCDHHS Program Integrity requires, such as the Termination for Cause List, the Suspended List, and the Behavioral Health Actions List.
- CCME's review of the organizational credentialing files reflect appropriate documentation except for proof of query of the Suspended List, and the Behavioral Health Actions List.
- *Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination* and *Policy SC_PNXX_309, Excluded and Debarred Providers* do not include the Suspended List and the Behavioral Health Actions List SCDHHS Program Integrity requires.

- *Policy MCD-11, Medicaid Access/Availability Standard* does not address the drive time requirements for measuring provider access as specified in the *SCDHHS Policy and Procedure Guide, Section 6.2*.
- It was noted the online *Provider Directory* and the printed copy received in the desk materials do not address access for individuals with physical disabilities.
- Low response from the BlueChoice 2018 physician office appointment access survey, measuring adherence to appointment standards, caused the data to be unreliable.
- The results of the *Telephonic Provider Access Study* CCME conducted reflect calls were answered successfully 57% of the time (147 of 260) when omitting 33 calls answered by voicemail messaging services. When compared to last year's results of 69%, the decrease in successful answer rate was statistically significant.
- The website-link for the clinical practice guidelines (CPG) for Celiac Disease does not work.

Quality Improvement Plans

- Update the *Healthy Blue Credentialing Program Plan* and *Policies MCD-04* and *MCD-05* to include the Suspended List and Behavioral Health Actions List as required queries.
- For *Policy MCD-04*, remove the reference to retired *Policy MCD-02*.
- Ensure credentialing and recredentialing files contain proof of all queries required by SCDHHS Program Integrity.
- Update the "Queries Performed" section of *Policy MCD-06, Health Care Delivery Organizations – Credentialing/Recredentialing* to reflect the following queries: Termination for Cause List, Suspended List, and Behavioral Health Actions List.
- Ensure organizational credentialing and recredentialing files contain proof of query of the Suspended List and the Behavioral Health Actions List.
- Update *Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination* and *Policy SC_PNXX_309, Excluded and Debarred Providers* to include the following lists SCDHHS Program Integrity requires: Suspended List and Behavioral Health Actions List.
- Internal processes and information systems related to updating provider information should be reviewed to ensure contact information for providers is accurate and updated in a timely manner. Create a policy or document that explains the methods used to ensure accuracy of the provider contact information for the BlueChoice provider network.

Recommendations

- Update *Policy MCD-11, Medicaid Access/Availability Standard* to include the drive time requirements as defined in the *SCDHHS Policy and Procedure Guide, Section 6.2.*
- Ensure the *Provider Directory* addresses the provider's ability to accommodate individuals with physical disabilities.
- Continue to monitor practitioner/provider appointment availability to ensure members have access to their providers within the defined timeframes.
- Correct the link for the Celiac Disease CPG on the website.

C. Member Services

The review of Member Services included policies and procedures, member rights, member informational materials, grievances, and the *Member Satisfaction Survey*. BlueChoice's member handbook is known as the *Evidence of Coverage*. It is thorough, easily understood, and meets the sixth-grade reading comprehension level as required by SCDHHS.

BlueChoice's website has quick links and resources for members to access information. During the onsite, CCME discussed its finding that some information on topics such as Advance Directives and preventive health guidelines on the website is limited or is not easily located. Recommendations for improvement were provided. The *Evidence of Coverage*, which is also located on the website, informs members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions on how to access benefits. Additionally, the handbook provides information on obtaining Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The handbook is available in Spanish and alternate formats including large font, audio, and Braille. Member Services staff are available per contract requirements via a toll-free number. Text telephone (also known as TTY) services are available for members with hearing difficulties. Members are informed that translation services are available for calls and during appointments with providers.

The toll-free Customer Care Center (CCC) telephone number routes calls to Interactive Voice Response (IVR) menus that allow callers to reach appropriate staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Standard Time, Monday through Friday. After hours, the IVR provides instructions to call 911 for an emergency, provides normal operating hours, and an option to leave a confidential voicemail for CCC staff. Callers also have the option to transfer to the 24-hour Nurse Advice Line.

BlueChoice contracts with DSS Research, a certified *Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* vendor to conduct both the *Child* and *Adult Surveys*. Survey results were presented to the Quality Improvement Committees and to

providers. Survey sample sizes were adequate, and although response rates were above the national average, they were below the National Committee for Quality Assurance (NCQA) target of 40%. For adults, the response rate was 26.8% and the 2017 national average was 23.3%. For the *Child Survey*, the response rate was 23.31% and the national average was 22.3%. The number of completed surveys for total population in the child with chronic conditions surveys was 964, with a response rate of 24.33% which is above the national average in 2017 of 22.3%.

CCME identified a discrepancy in documentation of grievance record retention practices; however, onsite discussion confirmed grievance logs and records are kept for a minimum of 10 years. Additionally, CCME noted a discrepancy in documentation of the timeframe for which grievances are resolved. The Grievance Acknowledgement Letter and the "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" letter attachment states grievances are resolved within 90 calendar days from receipt of the grievance. However, staff confirmed grievances are resolved within 30 days. CCME informed BlueChoice both discrepant areas were identified as deficiencies with resulting Quality Improvement Plans during the 2018 EQR.

Review of grievance files reflect timely acknowledgement and resolution, and consistent documentation in the call tracking system.

As noted in *Figure 5: Member Services Findings*, BlueChoice achieved a "Met" score for 94% of the Member Services standards.

Figure 5: Member Services Findings

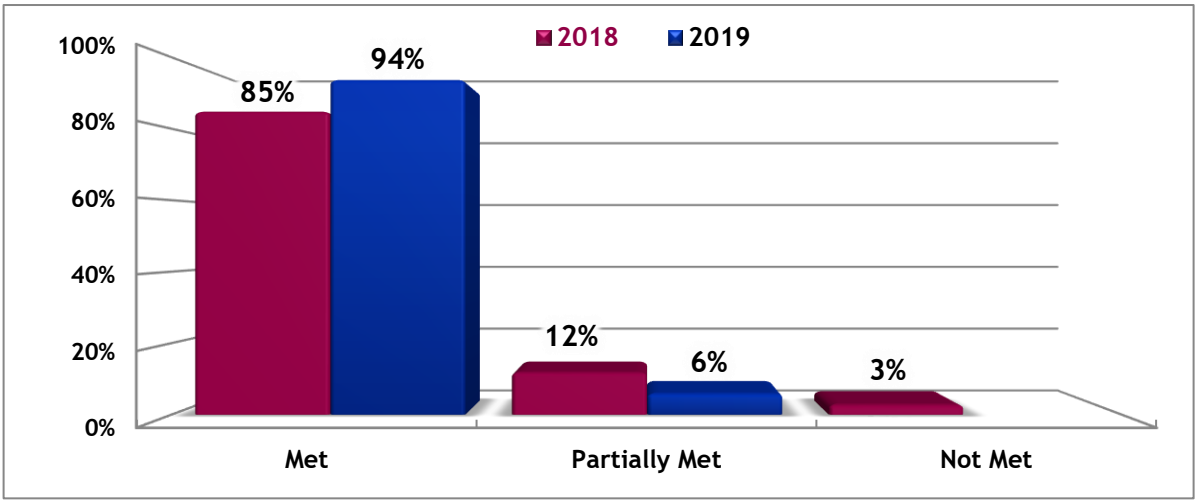


Table 8: Member Services Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information	Partially Met	Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: the procedure for filing and handling a grievance	Not Met	Met
	The MCO applies the grievance policy and procedure as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- The member website has titles and headings written in Spanish directly on main pages.
- Grievance Resolution Letters are detailed and give responses specific to the member's grievance.
- Staff consistently conduct Health Insurance Portability and Accountability Act (HIPAA) verification and address gaps in care with members during grievance calls.

Weaknesses

- *Policy SC_COXX_126, Annual Notification to Members* does not indicate the timeframe for informing new members of all benefit information. It also does not include information describing the *Evidence of Coverage* is issued within five business days of a member's request or that *Provider Directories* are issued within 48 hours.
- Since the term "formulary" is neither explained nor defined on the Pharmacy Information page of the member's website, members may not understand that it is referring to the *Preferred Drug List* (PDL).
- Page 3 of *Policy SC_QMXX_074, Advance Directives* provides an incorrect link for staff to instruct members to obtain information.
- The *Evidence of Coverage* and Annual Newsletter do not inform members of their right to request an *Evidence of Coverage* and *Provider Directory* as documented in *Policy, SC_COXX_126, Annual Notification to Members*.

- *Policy SC_GAXX_015, Grievance Process: Members* does not completely indicate that following an extension of the resolution timeframe, the MCO must make reasonable efforts to give members prompt oral notice of the delay and within two calendar days give the member written notice of the reason, as required in the *SCDHHS Contract, Section 9.1.6.1.5*.
- *Policy SC_GAXX_015, Grievance Process: Members* indicates BlueChoice resolves grievances and provides notice within 30 days of receipt. However, the *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment state grievances are resolved within 90 calendar days from the date of receipt. During the onsite, staff confirmed grievances are resolved within 30 calendar days. BlueChoice was reminded that documentation of incorrect resolution timeframes was identified as a deficiency during the 2018 EQR.
- Page 8, Section R of *Policy SC_GAXX_015, Grievance Process: Members* indicates grievance logs and grievance records are retained for five years and states, "Electronic files are maintained for longer than 5 years." However, the Anthem Record Retention Schedule indicates records are kept for 10 years. Onsite discussions confirmed BlueChoice follows Anthem's record retention policy and maintains grievance logs and records for a minimum of 10 years. BlueChoice was reminded that documentation of incorrect record retention timeframes was identified as a deficiency during the 2018 EQR.
- Response rates for the CAHPS Adult and Child Surveys were below the NCQA target of 40%.

Quality Improvement Plans

- Revise the *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment to reflect grievances are resolved within 30 calendar days of receipt.
- Edit *Policy SC_GAXX_015, Grievance Process: Members* to include the complete requirements found in the *SCDHHS Contract, Section 9.1.6.1.5* for extension of the resolution timeframe .
- Edit *Policy SC_GAXX_015, Grievance Process: Members* to indicate grievance logs and records are maintained for a minimum of 10 years as the *SCDHHS Contract, Section 19.35.3* requires.

Recommendations

- Edit *Policy SC_COXX_126, Annual Notification to Members* to include timeframes when new members are informed of benefit information as the *SCDHHS Contract, Section*

3.14.3 requires. Also, indicate that paper copies of member information are provided within five business days, without charge, upon request as the *SCDHHS Contract Section, 3.13.1.5* requires.

- Edit the Pharmacy Information page of the member's website to define the term "formulary" or replace it with the term "PDL."
- Edit *Policy SC_QMXX_074, Advance Directives* with a correct link to obtain Advanced Directive forms or remove the link from the policy.
- Revise *Policy, SC_COXX_126 Annual Notification to Members* by removing language that members are informed in the *Evidence of Coverage* and Annual Newsletter of their rights to request an *Evidence of Coverage* (member handbook) or *Provider Directory* yearly or include the appropriate language in the *Evidence of Coverage* and Annual Newsletter. Additionally, edit the policy to include members are notified annually in writing of this right.
- Continue working with DSS Research to increase response rates for CAHPS Adult and Child surveys.

D. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed program descriptions, committee structure and minutes, performance measures, performance improvement projects (PIPs), and the QI program evaluation. BlueChoice's *2019 Medicaid Quality Management Program Description* describes the program's QI structure, function, scope, and goals as defined by the health plan. BlueChoice's Medicaid Board of Directors has ultimate authority and accountability for the QI Program. This Board of Directors has delegated the responsibility for development and implementation to the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC). Both committees are responsible for monitoring and evaluating the results of quality initiatives and initiating improvements projects when areas needing improvement are identified.

The Associate Medical Director chairs the CQIC and membership includes contracted primary and specialty care physicians. The specialties of the contracted providers include family medicine, pediatrics, OB-GYN, and emergency medicine. A behavioral health Medical Director is included as a member of the committee; however, a contracted behavioral health provider is not included.

The *2019 Medicaid Quality Management Program Description* includes information regarding the adoption of clinical practice and preventive health guidelines. *Policy SC_QMXX_048, Clinical Practice Guidelines – Review, Adoption and Distribution* discusses monitoring provider compliance with the guidelines. This policy mentions provider compliance is assessed through medical record audits, monitoring utilization data, and

Healthcare Effectiveness Data Information Set (HEDIS) performance gap-in-care data. Reports of the monitoring were not found in the desk materials. This was discussed during the onsite visit and staff indicated the monitoring was conducted during the medical record audits. A copy of the audit tool and results were provided.

The *2018 Quality Management Program Work Plan Annual Evaluation* was provided. Because the program evaluation was a draft, the SQIC or the CQIC neither reviewed nor approved it. Staff indicated they were in the process of completing the evaluation and will be submitting the document to the committees. There appeared to be sections of the document that contained incorrect or incomplete information. For example, on page 24 of the Quality of Care Review section, the wrong definition of a grievance was used. The data indicated there were four grievances related to Quality of Care. However, the analysis did not address Quality of Care. Tables on page 30 seemed out of place. Page 75 references a table that was missing. In the Clinical Quality Improvement Activities section only the Effectiveness of Care Measures are displayed. On pages 106 to 112 in the PIPs section, there is no mention of the Childhood Immunizations Combo 3 and Lead Screening PIP.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

BlueChoice uses Inovalon, a certified software organization, for calculation of HEDIS rates and the validation found all requirements were met. The 2016 rate, the 2017 rate, and the change in rate are presented in *Table 9: HEDIS Performance Measure Data*.

Table 9: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	83.06%	85.40%	2.34%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	73.38%	76.40%	3.02%
Counseling for Nutrition	60.88%	65.45%	4.57%
Counseling for Physical Activity	51.85%	52.80%	0.95%
Childhood Immunization Status (cis)			
DTaP	75.46%	72.99%	-2.47%

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
IPV	88.89%	89.05%	0.16%
MMR	93.06%	88.56%	-4.50%
HiB	83.33%	85.16%	1.83%
Hepatitis B	86.11%	88.08%	1.97%
VZV	91.44%	88.56%	-2.88%
Pneumococcal Conjugate	79.17%	76.89%	-2.28%
Hepatitis A	87.27%	83.94%	-3.33%
Rotavirus	74.07%	70.07%	-4.00%
Influenza	46.30%	42.09%	-4.21%
Combination #2	68.98%	69.83%	0.85%
Combination #3	66.90%	67.88%	0.98%
Combination #4	65.05%	65.69%	0.64%
Combination #5	57.87%	56.69%	-1.18%
Combination #6	37.27%	37.47%	0.20%
Combination #7	56.48%	55.47%	-1.01%
Combination #8	37.04%	37.47%	0.43%
Combination #9	34.03%	32.36%	-1.67%
Combination #10	33.80%	32.36%	-1.44%
Immunizations for Adolescents (ima)			
Meningococcal	62.04%	69.10%	7.06%
Tdap	80.32%	82.97%	2.65%
HPV	14.58%	25.06%	10.48%
Combination #1	60.19%	67.64%	7.45%
Combination #2	13.43%	22.63%	9.20%
Lead Screening in Children (lsc)	68.06%	68.61%	0.55%
Breast Cancer Screening (bcs)	49.19%	51.86%	2.67%
Cervical Cancer Screening (ccs)	52.47%	58.15%	5.68%
Chlamydia Screening in Women (chl)			

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
16-20 Years	47.43%	49.63%	2.20%
21-24 Years	61.76%	62.95%	1.19%
Total	53.16%	54.72%	1.56%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	76.93%	84.17%	7.24%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	28.74%	23.21%	-5.53%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	63.86%	51.19%	-12.67%
Bronchodilator	71.81%	66.88%	-4.93%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	54.41%	54.15%	-0.26%
5-11 Years: Medication Compliance 75%	26.05%	26.88%	0.83%
12-18 Years: Medication Compliance 50%	50.97%	51.23%	0.26%
12-18 Years: Medication Compliance 75%	24.12%	24.91%	0.79%
19-50 Years: Medication Compliance 50%	51.43%	50.31%	-1.12%
19-50 Years: Medication Compliance 75%	30.48%	26.42%	-4.06%
51-64 Years: Medication Compliance 50%	60.61%	66.67%	6.06%
51-64 Years: Medication Compliance 75%	39.39%	42.42%	3.03%
Total: Medication Compliance 50%	53.27%	53.10%	-0.17%
Total: Medication Compliance 75%	26.52%	26.75%	0.23%
Asthma Medication Ratio (amr)			
5-11 Years	82.57%	80.29%	-2.28%
12-18 Years	72.34%	64.97%	-7.37%
19-50 Years	51.75%	51.10%	-0.65%
51-64 Years	56.25%	54.72%	-1.53%
Total	73.77%	69.02%	-4.75%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	41.92%	47.45%	5.53%

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	61.29%	70.00%	8.71%
Received Statin Therapy: 21-75 Years (Male)	74.59%	75.63%	1.04%
Statin Adherence 80%: 21-75 Years (Male)	55.80%	57.05%	1.25%
Received Statin Therapy: 40-75 Years (Female)	77.06%	74.23%	-2.83%
Statin Adherence 80%: 40-75 Years (Female)	50.38%	50.00%	-0.38%
Received Statin Therapy: Total	75.77%	74.94%	-0.83%
Statin Adherence 80%: Total	53.16%	53.58%	0.42%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	83.10%	84.91%	1.81%
HbA1c Poor Control (>9.0%)	47.92%	48.18%	0.26%
HbA1c Control (<8.0%)	44.91%	42.34%	-2.57%
Eye Exam (Retinal) Performed	34.72%	42.82%	8.10%
Medical Attention for Nephropathy	92.13%	91.73%	-0.40%
Blood Pressure Control (<140/90 mm Hg)	52.55%	50.36%	-2.19%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	60.64%	57.94%	-2.70%
Statin Adherence 80%	48.21%	45.64%	-2.57%
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	58.89%	71.91%	13.02%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	42.53%	45.07%	2.54%
Effective Continuation Phase Treatment	25.72%	30.08%	4.36%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	37.61%	34.88%	-2.73%
Continuation and Maintenance (C&M) Phase	51.68%	46.71%	-4.97%

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	NR	63.51%	NA
7-Day Follow-Up	NR	36.03%	NA
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	37.20%	45.50%	8.30%
7-Day Follow-Up	24.86%	27.30%	2.44%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: 13-17 Years	5.26%	21.21%	15.95%
7-Day Follow-Up: 13-17 Years	5.26%	15.15%	9.89%
30-Day Follow-Up: 18+ Years	15.15%	15.53%	0.38%
7-Day Follow-Up: 18+ Years	10.47%	10.35%	-0.12%
30-Day Follow-Up: Total	14.66%	16.00%	1.34%
7-Day Follow-Up: Total	10.21%	10.75%	0.54%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.51%	74.31%	-1.20%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	69.23%	57.78%	-11.45%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	66.67%	66.67%	0.00%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	59.82%	57.47%	-2.35%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	11.11%	57.14%	46.03%*
6-11 Years	18.97%	20.27%	1.30%
12-17 Years	23.81%	21.77%	-2.04%
Total	21.76%	22.44%	0.68%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	86.94%	88.33%	1.39%
Digoxin	55.00%	NR	NA
Diuretics	87.00%	87.43%	0.43%

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
Total	86.80%	87.92%	1.12%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.56%	0.54%	-1.02%
Appropriate Treatment for Children With URI (uri)	84.40%	85.97%	1.57%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	24.40%	29.13%	4.73%
Use of Imaging Studies for Low Back Pain (lbp)	75.41%	73.88%	-1.53%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
*1-5 Years**	NA	NA	NA
6-11 Years	2.27%	0.00%	-2.27%
12-17 Years	0.00%	0.00%	0.00%
Total	0.71%	0.00%	-0.71%
Use of Opioids at High Dosage (uod)		61.02	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers		261.62	NA
Multiple Pharmacies		58.48	NA
Multiple Prescribers and Multiple Pharmacies		26.47	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	75.74%	76.32%	0.58%
45-64 Years	85.99%	85.56%	-0.43%
*65+ Years**	100.00%	NA	NA
Total	78.79%	79.00%	0.21%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.08%	96.52%	0.44%
25 Months - 6 Years	85.99%	85.19%	-0.80%
7-11 Years	87.49%	88.11%	0.62%
12-19 Years	85.73%	85.54%	-0.19%
Initiation and Engagement of AOD Dependence Treatment (iet)			

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years		18.18%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years		9.09%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years		100.00%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years		0.00%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years		40.57%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years		24.53%	NA
Initiation of AOD Treatment: 13-17 Years	31.52%	36.75%	5.23%
Engagement of AOD Treatment: 13-17 Years	14.13%	22.22%	8.09%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years		38.59%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years		9.20%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years		49.64%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years		18.98%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years		37.25%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years		11.53%	NA
Initiation of AOD Treatment: 18+ Years	36.40%	38.30%	1.90%
Engagement of AOD Treatment: 18+ Years	9.59%	10.98%	1.39%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total		37.88%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total		9.19%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total		49.82%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total		18.91%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total		37.60%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total		12.90%	NA
Total: Initiation of AOD Treatment: Total	36.12%	38.19%	2.07%
Total: Engagement of AOD Treatment: Total	9.85%	11.78%	1.93%

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	PERCENTAGE POINT DIFFERENCE
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	89.56%	91.09%	1.53%
Postpartum Care	70.53%	67.82%	-2.71%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	71.43%	16.67%	-54.76%*
6-11 Years	48.39%	56.25%	7.86%
12-17 Years	24.59%	55.56%	30.97%
Total	35.35%	53.01%	17.66%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.78%	0.83%	-1.95%
1 Visit	2.31%	0.83%	-1.48%
2 Visits	3.01%	2.78%	-0.23%
3 Visits	3.24%	4.44%	1.20%
4 Visits	9.72%	6.39%	-3.33%
5 Visits	10.65%	10.56%	-0.09%
6+ Visits	68.29%	74.17%	5.88%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	66.17%	65.23%	-0.94%
Adolescent Well-Care Visits (awc)	47.45%	48.66%	1.21%

NR = Not Reportable; NA= Not Applicable due to missing data;=small denominator*

The comparison from the previous to the current year revealed a substantial improvement (>10%) in Immunizations for Adolescents – HPV, Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence for 13-17 year-olds, Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5 year-olds, and Psychosocial Care for Children and Adolescents on Antipsychotics for 12-17 year-olds and the overall Total Rate. The measures that decreased were Diabetes Monitoring for People With Diabetes and Schizophrenia and Pharmacotherapy Management of COPD Exacerbation -Systemic Corticosteroid. *Table 10: HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from 2016 to 2017.

Table 10: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2017	Change from 2016 to 2017
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescence			
HPV	14.58%	25.06%	10.48%
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	58.89%	71.91%	13.02%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence			
13-17 Years	5.26%	21.21%	15.95%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	11.11%	57.14%	46.03%*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
12-17 Years	24.59%	55.56%	30.97%
Total	35.35%	53.01%	17.66%
Substantial Decrease in Rate (>10% decrease)			
Diabetes Monitoring for People With Diabetes and Schizophrenia	65.38%	51.35%	-11.45%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	63.86%	51.19%	-12.67%

BlueChoice reported 12 quality clinical withhold measures for 2017. Per the *SCDHHS Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by individual measure weights then summed to obtain the quality index score. The 2017 rate, percentile, point value, and index score are shown in *Table 11: Quality Withhold Measures*. The Pediatric Preventive Care rates generated the highest index score, followed by Women's Health, and then Diabetes.

Table 11: Quality Withhold Measures

Measure	2017 Rate	2017 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	84.91%	25	3	3.2
HbA1c Control (< =9)	48.18%	25	3	
Eye Exam (Retinal) Performed	42.82%	25	3	
Medical Attention for Nephropathy	91.73%	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	91.09%	90	6	4.2
Breast Cancer Screen	51.86%	25	3	
Cervical Cancer Screen	58.15%	25	3	
Chlamydia Screen in Women (Total)	54.72%	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	74.17%	90	6	4.3
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.23%	25	3	
Adolescent Well-Care Visits	48.66%	50	4	
Weight Assessment/Adolescents: BMI % Total	76.40%	50	4	

Performance Improvement Project Validation

The validation of the PIPs was done in accordance with the CMS-developed protocol entitled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed include the following:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

BlueChoice submitted three projects. They included Access and Availability of Care, Childhood Immunizations Combo 3 and Lead Screenings, and Comprehensive Diabetes Care. The Childhood Immunizations Combo 3 and Lead Screenings project was noted as retired and the Comprehensive Diabetes Care project was new. The documentation received for the Comprehensive Diabetes Care PIP was missing data. This was discussed during the onsite and BlueChoice provided a brief summary of the results and analysis. CCME combined the PIP report and brief summary for validation.

Interventions were initiated in 2017 for the Access and Availability of Care PIP and the results section was revised to align with benchmark and goal rates. However, the rates for this PIP continue to decrease instead of increase. During the onsite visit, new interventions were discussed including home visits, enhanced IVR calls, and the automated texting campaign.

Both projects received a score within the "High Confidence in Reported Results" level. *Table 12: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 12: Performance Improvement Project Validation Scores

PROJECT	2018 VALIDATION SCORE	2019 VALIDATION SCORE
Access and Availability of Care	83% Confidence in Reported Results	99% High Confidence in Reported Results
Childhood Immunizations Combo 3 and Lead Screenings	83% Confidence in Reported Results	Retired, Not Validated
Comprehensive Diabetes Care	Not Validated	100% High Confidence in Reported Results

The recommendations for correcting the errors identified in the Access and Availability of Care PIP are displayed in *Table 13: Performance Improvement Project Errors and Recommendations.*

TABLE 13: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Access and Availability of Care	Was there any documented, quantitative improvement in processes or outcomes of care?	No, both rates decreased instead of improving (increasing).	Implement new interventions or revise ongoing interventions to improve rates.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

BlueChoice "Met" all the Standards in the QI section. *Figure 6: Quality Improvement Findings* provides an overview of the scores in 2017 compared to the current review scores.

Figure 6: Quality Improvement Findings

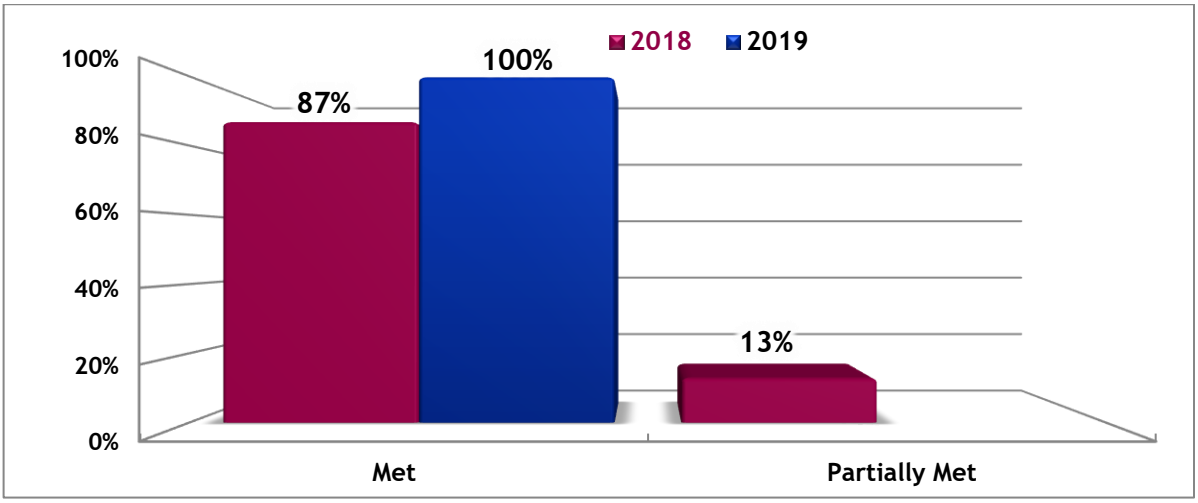


TABLE 14: Quality Management Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
The Quality Improvement (QI) Program	The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines	Partially Met	Met

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Weaknesses

- A contracted behavioral health provider is not included as a member of the CQIC.
- The *2018 Quality Management Program Work Plan Annual Evaluation* was incomplete and contained inaccurate information.

Recommendations

- Include a contracted behavioral health provider as a member of the CQIC.
- Ensure the documentation is complete and accurate in the *Quality Management Program Work Plan Annual Evaluation*.

E. Utilization Management

BlueChoice partners with Amerigroup to administer the utilization management activities for its Medicaid line of business. The *Utilization Management (UM) Program Description* includes the program's purpose, scope, objectives, structure, staff qualifications and responsibilities, and describes key aspects of the UM Program. Separate policies provide additional detail on specific UM processes and requirements.

During CCME's review of the *UM Program Description*, UM policies, and related documentation, issues were identified related to timeliness guidelines of UM determinations, including incorrect information about the timeframe allowed for submission of information when an extension has been implemented for standard, preservice authorization requests and the point in time the extension period begins.

In 2016, BlueChoice established a Preferred Provider Program that offers a specific subset of providers an opportunity to earn Gold Card status for the prior authorization process. Criteria for program eligibility are defined in policy and the program is evaluated annually for amendment. Providers who have achieved Gold Card status are audited annually to determine continued eligibility for the program. All providers are informed of the program via the *Provider Manual*.

Processes have been implemented for the application of medical necessity criteria, ensuring that individual member circumstances (such as age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment,

when applicable) and the availability of services within the local delivery system are considered. Consistency in application of medical necessity criteria and decision-making is assessed through an annual inter-rater reliability (IRR) process. Both physician and non-physician reviewers are included in the IRR process, and results are reported to the health plan, Chief Medical Officer/designated National Medical Directors, and the Quality Improvement Committees and/or Medical Operations Committee.

CCME's review of UM approval and denial files confirmed appropriate medical necessity criteria are applied and relevant clinical information is requested when necessary. Although all determinations were made within the required timeframe, two notice of adverse benefit determination letters were not sent within the contractually required timeframe.

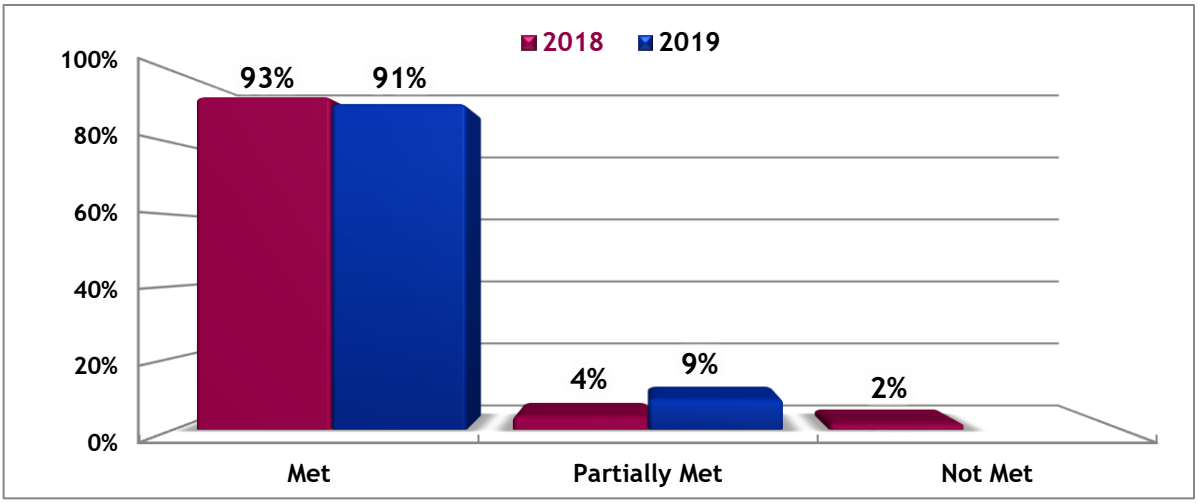
CCME identified issues within the documentation of appeals handling and resolution processes, including outdated terminology, an incomplete definition of appeal terminology, errors in the timeframe to file an appeal and the timeframe to request a State Fair Hearing, errors in the resolution timeframe for expedited appeals, and incomplete information regarding requirements for continuation of benefits. Despite these documentation issues, appeal file review findings indicate, overall, staff follow appropriate processes in the handling and resolution of appeals. One file was found to have an untimely resolution, and this was discussed during the onsite visit. Staff reported this was an error by health plan staff. Appeal data is tracked, trended, and reported to appropriate committees.

Case management (CM), care coordination, and care transitions processes conducted by the plan are described in various program descriptions and associated policies. CM files reflected appropriate assessment, monitoring, care plan development and revision, referrals and teaching to address barriers, and interventions to progress toward goals. BlueChoice evaluates member satisfaction with the CM Program through a telephonic member satisfaction survey process conducted by an external vendor. From February 2018 to February 2019, satisfaction rates ranged from 91% to 95%.

BlueChoice conducts an annual evaluation of the UM Program. The *2018 Utilization and Case Management Program Annual Evaluation* includes program accomplishments, opportunities, performance summaries, an evaluation of program structure effectiveness, and an evaluation of program activity related to UM, over- and under-utilization, IRR, member and provider satisfaction with UM, member satisfaction with CM, a summary of readmission prevention activities, and activities related to prevention of unnecessary emergency room utilization. It concludes with recommendations for the next calendar year.

As noted in *Figure 7, Utilization Management Findings*, BlueChoice achieved "Met" scores for 91% of the UM standards.

Figure 7: Utilization Management Findings



Totals may not equal 100% due to rounding

TABLE 15: Utilization Management Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: the definitions of an adverse benefit determination and an appeal and who may file an appeal;	Met	Partially Met
	Other requirements as specified in the contract	Met	Partially Met

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Care Management and Coordination	The MCO has a designated Transition Coordinator who meets contract requirements	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Monthly internal audits of appeal files are conducted to verify compliance with regulatory and accreditation requirements. Audit performance data is analyzed, and corrective actions are implemented for any issues identified.

Weaknesses

- The *SCDHHS Contract, Section 8.6.1.3* and *42 CFR § 438.210 (d) (1)* allow 14 days for a standard pre-service determination with a possible extension of 14 additional days under specific circumstances. Page 21 of the *UM Program Description* indicates for plan-initiated extensions of standard (non-urgent) authorization timeframes due to insufficient clinical information, members (or member representatives) are given 45 calendar days to provide the needed information. It further states the extension period, within which a decision must be made by the plan, begins on the date the organization receives the member's response or at the end of the time period given to the member to supply the information if no response is received from the member or the member's representative.
- The following statement was noted on the BlueChoice website: "Services requiring prior authorization (PA) for BlueChoice HealthPlan Medicaid members enrolled in the Healthy Connections program can be found by viewing the PA grid on our website." However, CCME was unable to locate the referenced PA grid on the website.
- Page 2 of *Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies* states for sterilization requests, the *Surgical Justification Review for Hysterectomy* form is required along with the signed *Consent for Sterilization* form (HHS -687). This requirement is also stated on page 63 of the *Provider Manual*. Onsite discussion confirmed this is an error and sterilization requests do not require submission of the *Surgical Justification Review for Hysterectomy* form.
- Two UM denial files were noted to have adverse benefit determination letters sent outside of the contractually required timeframes.
- The BlueChoice website glossary uses the outdated term "action" instead of "adverse benefit determination." Also, the glossary's definition of an adverse benefit determination is incomplete — it is missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums,

deductibles, coinsurance, and other enrollee financial liabilities." Refer to the *SCDHHS Contract, Section 9.1 (b)* and *42 CFR § 438.400 (b)*.

- The *SCDHHS Contract, Section 9.1.1.2.2* allows 60 calendar days from the date on the adverse benefit determination notice to file an appeal. Issues noted with the timeframe to file an appeal include:
  - Page 53 of the *Evidence of Coverage* incorrectly states an appeal may be requested 60 calendar days from the date the notice is received.
  - Most of the initial *Notice of Adverse Determination* letter templates submitted in the desk materials state appeals may be requested "within 60 calendar days from the date you receive this letter." The *Initial Denial – Not a Covered Benefit* letter and the *Your Grievance and Appeal Rights as a Member of Healthy Blue* state the timeframe as within 90 calendar days from the date the letter is received. (CCME noted the notice of adverse benefit determination letters in the UM denial files state the correct timeframe.)
- Page 9 of *Policy SC_GAXX_051, Member Appeal Process* incorrectly states the timeframe to request a State Fair Hearing as 30 calendar days from receipt of the appeal resolution notice. The *SCDHHS Contract, Section 9.1.6.3.1.1* allows 120 calendar days from the date of the notice of resolution to request a State Fair Hearing.
- Page 93 of the *Provider Manual* appears to contain a discrepancy in documentation of the resolution timeframe for expedited appeals. It states both, "We resolve expedited appeals within 72 hours from the date Healthy Blue receives the request for an expedited appeal" and "We send a written resolution via certified mail within two calendar days from the date Healthy Blue receives the expedited appeal." Onsite discussion confirmed the expedited appeal resolution timeframe is within 72 hours of receipt of the appeal.
- Related to requests for continuation of benefits:
  - The definition of "timely filing" on page 65 of the *Evidence of Coverage* is missing "The intended effective date of the MCO's proposed adverse benefit determination." Refer to the *SCDHHS Contract, Section 9.1.7.1.*
  - Page 65 of the *Evidence of Coverage* documents the circumstances under which the health plan must continue the member's benefits and states, "You're still covered after we gave you our first approval." As written, this could be interpreted as referring to the member being covered by (or enrolled in) the health plan rather than the contractual requirement, "the original period covered by the original authorization has not expired." Refer to the *SCDHHS Contract, Section 9.1.7.2.*
- CCME reviewed 20 appeal files. Of the 20 files, one was found to have the determination and notification outside of the required timeframes. Staff reported this

appeal was untimely because at the time of receipt, the appeal request was not assigned to an appeal nurse.

Quality Improvement Plans

- Revise page 21 of the *UM Program Description* to reflect correct information about the amount of time members/representatives can submit clinical information when a plan-initiated extension has been implemented and when the time period for the extension begins.
- Revise the website glossary to use the current term of "adverse benefit determination" rather than "action" and to include the complete definition of an adverse benefit determination.
- Correct the timeframe to file an appeal on page 53 of the *Evidence of Coverage*.
- Correct the timeframe to request a State Fair Hearing on page 9 of *Policy SC_GAXX_051*.
- Correct the discrepancy in the expedited appeal resolution and notification timeframe on page 93 of the *Provider Manual*.
- Correct the definition of timely filing related to requests for continuation of benefits on page 65 of the *Evidence of Coverage* to include the complete definition as stated in the *SCDHHS Contract, Section 9.1.7.1*.

Recommendations

- Revise the website (Home > Providers > Prior Authorization and Claims) to include the referenced PA grid or remove the reference from the website.
- Revise *Policy SC_UMXX_129* and the *Provider Manual* to remove the requirement for submission of the *Surgical Justification Review for Hysterectomy* form for sterilization authorization requests.
- Ensure written notice of adverse benefit determination letters are sent within the contractually required timeframes stated in the *SCDHHS Contract, Sections 8.6.1* and *8.6.2*.
- Review initial notice of adverse benefit determination letter templates and the *Your Grievance and Appeal Rights as a Member of Healthy Blue* letter attachment to ensure they reflect the correct appeal filing timeframe.
- Revise page 65 of the *Evidence of Coverage* to clarify they circumstances under which the plan must continue the member's benefits to indicate the originally approved authorization period for the services must not have expired. Refer to the *SCDHHS Contract, Section 9.1.7.2*.

- Ensure appeals are appropriately assigned to appeal staff so that resolutions and notifications are compliant with contractual requirements.

F. Delegation

Policy HP 003-12, Oversight of Delegated Activities defines processes to ensure all delegated activities remain compliant with the current delegation agreement and accreditation standards, and to identify mechanisms for corrective actions should noncompliance be identified.

Activities may be delegated to certain organizations or vendors by Letter of Agreement or by Contract. The scope of such delegated activities is defined in a delegation agreement. While BlueChoice may delegate certain functions, it maintains responsibility and accountability for oversight of delegated activities, including pre-delegation activities, ongoing monitoring, evaluation, and actions to improve identified opportunities.

BlueChoice's delegated services are listed in *Table 16: Delegated Entities and Services*.

Table 16: Delegated Entities and Services

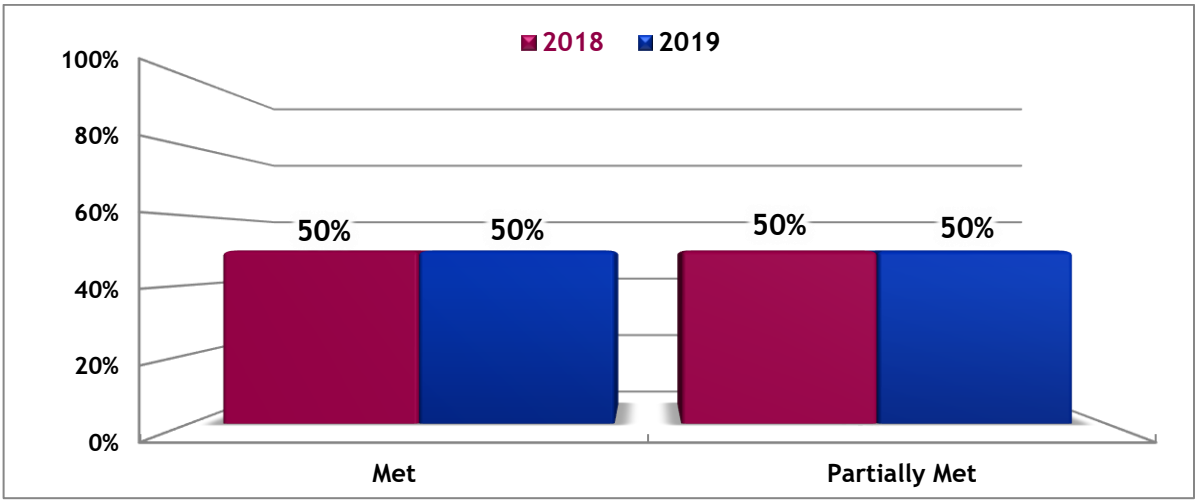
Delegated Entities	Delegated Services
• Greenville Hospital System • Roper St. Francis Physicians Network • VSP • Medical University of South Carolina • South Carolina Department of Mental Health • Palmetto Health USC Medical Group • AnMed Health • Spartanburg Regional Healthcare System	Credentialing/Recredentialing
Express Scripts, Inc. (ESI)	Pharmacy Services

Processes for delegated credentialing activities are defined in *Policy MCD-10, Credentialing Delegation*. A pre-delegation audit for proposed delegates is conducted to access a potential delegate's ability to credential providers following BlueChoice and SCDHHS criteria. The Credentialing Department conducts annual oversight of delegated entities to determine ongoing compliance. Corrective action plans are required for identified deficiencies. Section 4 of *Policy MCD-10* addresses queries that are included in the verification process; however, it does not include the following queries SCDHHS Program Integrity requires: Suspended List and Behavioral Health Actions List.

Evidence of annual oversight conducted within the last year was provided for all delegated entities. While the oversight reports were comprehensive and contained appropriate information, the credentialing and recredentialing oversight file review tool did not contain all queries SCDHHS Program Integrity requires. The Suspended List and the Behavioral Health Actions List were missing.

As indicated in *Figure 8: Delegation Findings* one of the two standards in the Delegation section is scored as "Partially Met."

Figure 8: Delegation Findings



Weaknesses

- Section 4 of *Policy MCD-10* addresses queries that are included in the verification process; however, it does not include the following queries SCDHHS Program Integrity requires: Suspended List and Behavioral Health Actions List.
- For delegated credentialing, the Suspended List and the Behavioral Health Actions List are not reflected as query requirements in the delegation oversight file review tool.

Quality Improvement Plans

- Update *Policy MCD-10, Credentialing Delegation* and the credentialing and recredentialing oversight file review tools to include the following queries SCDHHS Program Integrity requires: Suspended List and Behavioral Health Actions List.

G. State Mandated Services

BlueChoice ensures Early and Periodic Screening Diagnostic and Treatment (EPSDT) services for members through the month of their 21st birthday and has processes in place to notify and remind providers of needed EPSDT services. The *Provider Manual* notes

providers are monitored to verify compliance with EPSDT services and immunizations. Onsite discussions confirm BlueChoice monitors provider compliance through medical record reviews, and Healthcare Effectiveness Data Information Set (HEDIS) and claim reports.

BlueChoice provides all core benefits specified by the *SCDHHS Contract*.

CCME identified uncorrected deficiencies from the previous EQR. These include discrepancies in documentation of the grievance record retention practices and the timeframe for which grievances are resolved.

As indicated in *Figure 9: State Mandated Services*, 75% of standards in the State Mandated Services section are scored as "Met."

Figure 9: State Mandated Services

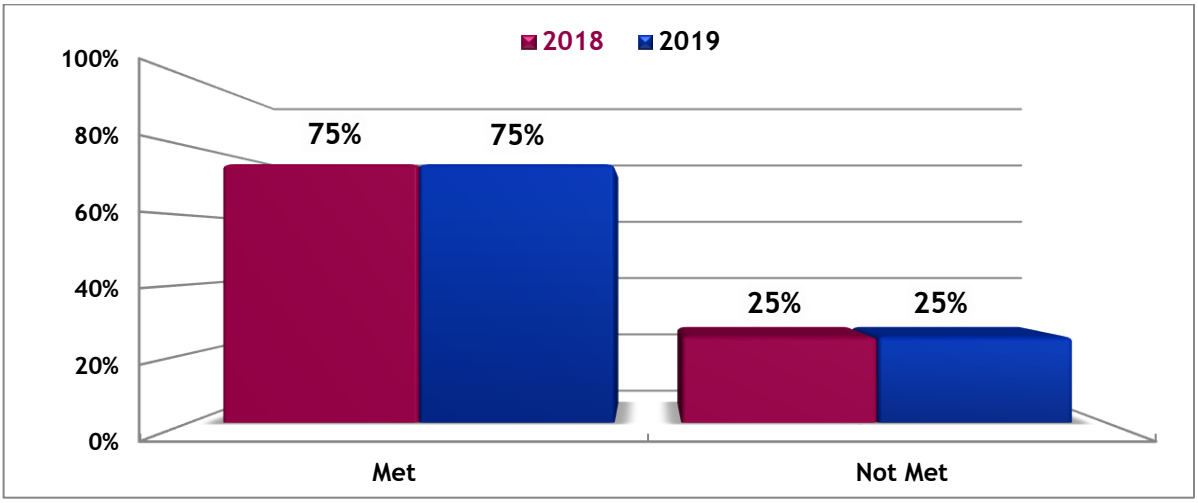


TABLE 16: State Mandated Services Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
The MCO tracks provider compliance with:	The MCO addresses deficiencies identified in previous independent external quality reviews.	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Weaknesses

- CCME identified uncorrected deficiencies from the previous EQR related to the following:

- Incorrect grievance resolution timeframes documented in the Grievance Acknowledgement Letter and the "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" letter attachment
- Incorrect grievance resolution timeframe documented in *Policy SC_GAXX_015, Grievance Process: Members*

Quality Improvement Plans

- Ensure all deficiencies are addressed and corrections are implemented.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

March 18, 2019

Mr. Daniel Gallagher
BlueChoice Health Plan
PO Box 6170, Mail Code AX-400
Columbia, SC 29260-6170

Dear Mr. Gallagher:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2019 External Quality Review (EQR) of BlueChoice Health Plan is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **May 16th and 17th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **April 01, 2019.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2018 and 2019.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from April 2018 through March 2019. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of April 2018 through March 2019.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey,

including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;

c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates. **Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.**

36. Provide electronic copies of the following files:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of April 2018 through March 2019. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of April 2018 through March 2019, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. BlueCross BlueShield of South Carolina Compliance Handbook (Our Values).
3. BlueCross BlueShield of South Carolina corporate policy on Fraud, Waste and Abuse (65020).
4. Documentation (policies, procedures, etc.) of processes used for initial and ongoing monitoring of the exclusion status of subcontractors, employees, persons with an ownership or control interest, and/or persons who are agents of the health plan. Please include documentation related to the specific federal databases queried as well as the databases/lists required by SCDHHS Program Integrity.
5. Pharmacy Services Compliance Plan (as referenced on page 9 of the Compliance Plan).
6. Copy of the BlueChoice HealthPlan Medicaid Practitioner Access Analysis January 1, 2018 to December 31, 2018.
7. Copy of the Companion Benefit Alternatives 2019 Medicaid Availability Analysis Behavioral Health Practitioners (Measurement Year 2018).
8. Copy of the provider Appointment and After-Hours access study conducted in 2018.
9. Grievance Acknowledgment letter template.
10. Grievance Acknowledgment letter attachment - “Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid.”
11. Policy SC_GAXX_015, Grievance Process: Members.
12. Copies of the following Pharmacy policies:
    - Prior Authorization Policy
    - Out of State Prescriptions Policy
    - Lost/Stolen/Vacation Supply Request Policy
    - After Hours Calls Policy

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**BlueChoice**
Name of PIP:	**COMPREHENSIVE DIABETES CARE (CLINICAL)**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Annual preventive care rate is below the Healthcare Effectiveness Data Information Set (HEDIS)50th percentile and rate of getting care is declining.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators are related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection occurrence is noted.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis will be once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions are documented in the report with new interventions noted in 2017.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis is performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and remeasurement data were presented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Follow-up analyses were noted in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology was used at repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Both rates decreased instead of improving (increasing). ***Recommendation:*** *Implement new interventions or revise ongoing interventions to improve rates.*
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement was reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement was reported.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	No improvement was reported.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	Study findings verified in HEDIS data file for AAP.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Activity 2	20	20

Project Score	124
Project Possible Score	125
Validation Findings	99%

CCME EQR PIP Validation Worksheet

Plan Name:	**BlueChoice**
Name of PIP:	**COMPREHENSIVE DIABETES CARE (CLINICAL)**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	A1C screening and eye exam rates are below the Healthcare Effectiveness Data Information Set (HEDIS) 50th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators are related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection occurrence is noted.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis will be once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions are documented in the report and were discussed during the onsite visit.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis is performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings for baseline are presented clearly in brief summary that was uploaded after the onsite meeting.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Follow-up analyses were noted in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	Study findings verified in HEDIS data file.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	1
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Activity 2	20	20

Project Score	118
Project Possible Score	118
Validation Findings	100%

CCME EQR PM Validation Worksheet

Plan Name:	**BLUECHOICE**
Name of PM:	**HEDIS**
Reporting Year:	**MY 2017**
Review Performed:	**2019**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2018 Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation was appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Denominator used correct data sources.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator was calculated accurately.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Numerator used correct data sources.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Numerator was calculated accurately.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Documentation was adequate.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Documentation was adequate.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Documentation was adequate.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Sampling was appropriate.
S2. Sampling	Sample treated all measures independently.	**MET**	Sampling performed appropriately.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sample size met specifications.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to State/HEDIS specifications?	**MET**	Measures were reported according to Healthcare Effectiveness Data Information Set specifications.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	**BlueChoice**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2018
Review Performed	2019

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA and was met. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with National Committee for Quality Assurance (NCQA) protocol and are clear and appropriate. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate are noted. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report* SQIC Meeting Minutes 11-16-18

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 26.8% (n=465 completed surveys) which is above the 2017 national average of 23.3%, but below the target NCQA rate of 40%. A low response rate can affect generalizability of the results.
7.4	What conclusions are drawn from the survey data?	About seven in 10 (72.28%) gave their health plan a rating of 8, 9 or 10 on a 0 to 10 scale, which is not significantly different from last year. About six in 10 (56.54%) gave a rating of 9 or 10, which is not significantly different from last year. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is encompassed in the results of CAHPS survey. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *DSS Research 2018 CAHPS® Adult Medicaid Survey Report*

CCME EQR Survey Validation Worksheet

Plan Name	**BlueChoice**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2018
Review Performed	2019

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA and was met. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate are noted. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report* SQIC Meeting Minutes 11-16-18

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 23.31% (above the national rate of 22.3% but below the target rate of 40% (n=497 completed surveys). A low response rate can affect generalizability of the results.
7.4	What conclusions are drawn from the survey data?	About nine in 10 (85.15%) gave their health plan a rating of 8, 9 or 10 on a 0 to 10 scale, which is not significantly different from last year. About seven in 10 (72.16%) gave a rating of 9 or 10, which is not significantly different from last year. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is encompassed in the results of CAHPS survey. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *DSS Research 2018 CAHPS® Child Medicaid Survey Report*

CCME EQR Survey Validation Worksheet

Plan Name	**BlueChoice**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2018
Review Performed	2019

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA and was met. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with National Committee for Quality Assurance (NCQA) protocol and are clear and appropriate. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate are noted. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report* SQIC Meeting Minutes 11-16-18

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The number of completed surveys for total population was 964, with a response rate of 24.33% which is above the national average in 2017 of 22.3%, but below the NCQA target. A low response rate can affect generalizability of the results.
7.4	What conclusions are drawn from the survey data?	About nine in 10 (85.37%) of the General population gave their health plan a rating of 8, 9 or 10 on a 0 to 10 scale, which is similar to last year and similar to the 2018 Gen. Pop. ANM Average. About eight in 10 (81.82%) of the CCC population gave a rating of 8, 9 or 10, which is similar to last year and similar to the 2018 CCC Pop. ANM Average. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is encompassed in the results of CAHPS survey. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *DSS Research 2018 CAHPS® Child CCC Medicaid Survey Report*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**BlueChoice HealthPlan of SC**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies are developed and maintained by business units or work areas, reviewed at least annually, and housed on a shared drive that all staff can access. During an onsite discussion, BlueChoice staff described policy management processes and indicated they are working to reduce redundancies in policies.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Tim Vaughn is the President and Chief Operating Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Chief Financial Officer (CFO);	X					The Chief Financial Officer is Jennifer Thorne.
1.3 * Contract Account Manager;	X					Amy Bennett is the Contract Account Manager.
1.4 Information Systems personnel;						Thomas Miller is Amerigroup's Chief Information Officer.
1.4.1 Claims and Encounter Manager/ Administrator,	X					Christopher Kearney is the Claims and Encounter Manager/Administrator, and Nicholas Von Gersdorff is Encounters Manager. Both are in Virginia.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Victoria McNeil-Brock is the Director, Utilization Management. Michael Brownlee is Manager, Case Management. The position of Manager, Medical Management was recently vacated and is being eliminated, which will open a new position for a clinical reviewer.
1.5.1 Pharmacy Director,	X					Jonathan Jones is the Pharmacy Director and is licensed by the South Carolina (SC) Board of Pharmacy.
1.5.2 Utilization Review Staff,	X					Utilization review staff are primarily located in SC with some positions held by staff in Georgia and Ohio.
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Kay Small is Director, Quality Management. Although not currently located in SC, she is relocating to the state and estimates this will occur by June 2019. In the interim, she spends approximately one week of each month in SC and reports she maintains close contact with Quality Management staff.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the Quality Management Director position is an in-state position as the SCDHHS Contract, Exhibit 1 requires.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Quality Management staff includes a Healthcare Effectiveness Data and Information Set (HEDIS) Coordinator, a Practice Consultant, Health Program Representatives, Clinical Quality Program Consultants, and an Outreach Care Specialist.
1.7 *Provider Services Manager;	X					Scott Timmons is Sr. Director, Provider Service Manager, and Shay Looker is Manager, Provider Services Staff.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Donna Williams is the Member Service Manager and Jessica Sisneros is the Customer Care Operations Expert Helpdesk Manager.
1.8.1 Member Services Staff,	X					Member Service staff includes Customer Care Representatives. Customer Care Operations Expert Helpdesk staff support the Customer Care Representatives.
1.9 *Medical Director;	X					Imtiaz Khan, DO (family practice) is the Medical Director. Dr. Khan is in SC. Kim Cooley, DO (board certified emergency medicine) is Associate Medical Director.
1.10 *Compliance Officer;	X					Rod Johnson is the Compliance Officer for BlueChoice. Laticia Mayfield is the Compliance Officer for Amerigroup.
1.10.1 Program Integrity Coordinator;	X					Debra Teeter is the Program Integrity Coordinator and Senior Investigator/Onsite Post-Payment Reviewer.
1.10.2 Compliance /Program Integrity Staff;	X					The Organizational Chart reflects adequate staffing is in place to conduct compliance and program integrity activities. One Compliance Consultant position is listed as vacant on the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Organizational Chart but, at the time of the onsite visit, is in process of being filled.
1.11 * Interagency Liaison;	X					Amy Bennett is the Interagency Liaison.
1.12 Legal Staff;	X					Melanie Joseph serves as Legal Counsel for BlueChoice.
1.13 Board Certified Psychiatrist or Psychologist;	X					Joel Axler, MD is a psychiatrist located in Georgia. Although not currently licensed in SC, he is in the process of obtaining licensure by the SC Board of Medical Examiners. He is certified by the American Board of Psychiatry and Neurology. *Recommendation: Ensure the board-certified psychiatrist or psychologist is licensed in the State of SC as the SCDHHS Contract, Exhibit 1 requires.*
1.14 Post-payment Review Staff.	X					As reported in the desk materials, Post-Payment Review staff includes 9 reviewers that cover all markets. All are qualified to conduct Post-Payment Reviews for the SC Medicaid market. Debra Teeter, Program Integrity Coordinator is a Senior Investigator and is an Onsite Post-Payment Reviewer in SC.
2. Operational relationships of MCO staff are clearly delineated.	X					The Organizational Chart reflects staffing for both BlueChoice and Amerigroup. When outside of SC, the Organizational Chart indicates the staff member's location.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					BlueChoice's *Information Systems Capabilities Assessment* (ISCA) documentation indicates that claims performance meets contractual requirements. To ensure accuracy, BlueChoice performs random audits of mass adjudicated claims monthly. BlueChoice also notes that systems are capable of being modified or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						updated to support any future claims policy requirements. Changes to BlueChoice's systems are reviewed by state compliance officials or controllers to ensure correct implementation. BlueChoice defines completeness as the ratio of the claims paid and incurred for a particular month as of a particular point in time to the estimated total incurred claims for that month. Based on a monthly average, BlueChoice states that 99% of claims are complete. BlueChoice bases its Medicaid claims/encounters processing standards on several factors: •Productivity – 95% of production standard •Quality: Financial Dollar Accuracy – 99.5%, Financial Incident Accuracy – 99%, Denial Accuracy – 98% •Encounters - 98% acceptance by the State (tracked via BlueChoice's Encounter Key Performance Indicator (KPI) reports)
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					BlueChoice's systems support electronic data in several formats including Health Insurance Portability and Accountability Act (HIPAA) 5010 Medical (837P), Institutional (837I) and Dental (837D) formats, National Council for Prescription Drug Programs (NCPDP) formats, and numerous proprietary formats.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					BlueChoice updates Medicaid enrollment information (834 transactions) daily (schedule is based on the state's frequency). To prevent duplication, data is analyzed by claim, encounter, and discharge data. Additionally, potentially duplicate data is processed by de-duplication algorithms. If multiple instances of one event are found, BlueChoice's systems de-duplicate the data to ensure redundant data is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						not processed. Finally, BlueChoice's systems use the state health plan ID, member name, date of birth, and Social Security Number to track member identities across multiple systems.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					BlueChoice licenses software certified by the National Committee for Quality Assurance (NCQA) to calculate HEDIS rates and reporting. The software's repository contains the required files, fields, and layouts for reporting.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Documentation demonstrates BlueChoice has a focus on best-practices IT security. In the documentation, BlueChoice noted that changes to access privileges require documented approval and audit trails. A physical security policy includes procedures to ensure facility access is limited to those authorized.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					In the ISCA documentation, BlueChoice noted that systems access is applied using security roles, and users receive only the minimum access required. Additionally, after five unsuccessful login attempts, accounts must be unlocked by an administrator.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					BlueChoice has business continuity plans (BCP) for its SC facilities. The plans are very detailed and include staff roles, procedures for emergency access, recovery priorities, and recovery time objectives. Additionally, the BCPs include processes, checklists, and instructions typically not found in BCPs, such as a bomb threat checklist, the nearest cross streets, and incident documentation forms. Finally, on November 26, 2018, BlueChoice successfully tested its ability to recover core systems. The recovery efforts were validated by the company's staff and met all recovery point objectives and recovery time objectives.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The *Healthy Blue by BlueChoice Health Plan of South Carolina Compliance Plan* (*Compliance Plan*) and the *Anthem Special Investigations Unit Antifraud Plan* (*Antifraud Plan*) describe activities and processes used to prevent, detect and respond to suspected and actual violations of ethical conduct standards and suspected or actual fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				See standards below for identified issues.
2.1 Standards of conduct;						BlueChoice's *Our Values* document serves as the code of conduct and outlines the principles of ethics and compliance that guide the health plan's daily operations. *Our Values* communicates the expectations that all management, employees, subcontractors, etc. conduct themselves in accordance with applicable laws, regulations, and company policies. The *Antifraud Plan* also addresses expectations that all employees abide by established standards of ethical conduct. The *Compliance Plan* indicates Plan supervisors, managers, directors, and officers are responsible for reinforcing the principles outlined in *Our Values* in their respective departments.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The *Compliance Plan* provides an overview of the role and responsibility of the Compliance Officer and indicates the Compliance Officer provides oversight for all Compliance activities and chairs the Compliance Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The roles and responsibilities of the Program Integrity Coordinator are not addressed in the *Antifraud Plan* or in the *Compliance Plan*, as the *SCDHHS Contract, Section 11.2.2.2* requires. *Quality Improvement Plan: Update the Antifraud Plan or Compliance Plan to include information about the roles and responsibilities of the Program Integrity Coordinator.*
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The *Compliance Plan* includes information about the Compliance Committee and includes the *Compliance Committee Charter*.
2.5 Compliance training and education;						Processes for initial and ongoing Compliance training are covered in the *Compliance Plan*. New employees must complete the *Our Values* training within 30 days of hire and all employees complete an annual refresher course covering ethics, the code of conduct, confidentiality and FWA. Annual education and training are provided for contractors on the False Claims Act and other relevant legislation, and updates on new and revised legislation that affects compliance. The *Antifraud Plan* indicates new employees must review and acknowledge agreement with the Compliance Program upon hire and annually. Employees are required to complete training on compliance and FWA within 30 days of employment. All employees receive annual refresher training. Providers and subcontractors are notified of consequences of participating in or contributing to FWA via their contract with the plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Specific processes for educating providers on compliance and FWA are found in *Policy MCD-01, Education of Contracting Providers*. The *Healthy Blue Fraud, Waste and Abuse* provider training presentation includes detailed information about FWA including provider responsibilities, definitions, compliance, the False Claims Act, whistleblower protections, other laws and regulations related to FWA, and reporting methods.
2.6 Lines of communication;						BlueChoice communicates compliance standards, policies, and procedures to staff and ensures staff can ask questions or make reports without fear of retaliation. Management staff are expected to maintain an " open door" environment and all staff can contact the Compliance Officer with questions or concerns. A confidential Fraud Hotline is available around the clock for staff, contractors, providers and members, and any other interested person(s) and allows anonymous reporting. The *Evidence of Coverage* and *Provider Manual* include information about methods to report suspected FWA by phone, fax, and mail.
2.7 Enforcement and accessibility;						The *Compliance Plan* indicates policies and procedures are consistently applied, regularly monitored, and enforced through appropriate activities such as education/training, progressive discipline, provider sanction or termination, and monetary recoupment, if applicable. Examples of conduct which could result in disciplinary action or sanction are provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Internal monitoring and auditing;						Monitoring and auditing processes used to identify issues that require corrective action are documented in the *Compliance Plan*. BlueChoice conducts an annual compliance risk assessment which then guides ongoing monitoring activities, establishes metrics, and requires corrective action for identified compliance issues and areas of identified risk. Findings and activities are reported to the Compliance Committee and executive staff.
2.9 Response to offenses and corrective action;						Incidents of non-compliance require an internal corrective action plan (CAP), which can include revising processes, updating policies or procedures, retraining staff, and reviewing systems edits and other root causes to be implemented. The Compliance Officer monitors implementation of the CAP, and the status of the CAP is reported to the Compliance Committee. Once the CAP is complete, the Compliance Officer conducts ongoing monitoring to ensure continued compliance. Incidents are disclosed to CMS and SCDHHS, as applicable.
2.10 Data mining, analysis, and reporting;						Data mining is the primary method of detecting and preventing provider FWA. Tools used include coding software, fraud and abuse analytics, and internal analytics. Examples of activities include: •Web-based summary reports of provider claims used to analyze abnormal trends and patterns •Benchmarking metrics for certain specialties used in ongoing provider engagement activities, including contracting •Data mining activities that identify macro behaviors that indicate possible FWA

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Exclusion status monitoring.						Processes for monitoring the exclusion status of subcontractors, persons with an ownership or control interest, or who are agents or managing employees of the health plan are incompletely documented in the *Compliance Plan* and in *Policy EP302, OIG/GSA Screening*. Page 8 of the *Compliance Plan* states, "We conduct pre-employment background checks on all potential employees, providers and contractors and review federal and state exclusion databases to ensure they have not been deemed ineligible to participate in our program. We review all employees and providers against federal and state exclusion databases on a monthly basis thereafter." However, the *Compliance Plan* does not specify the federal databases monitored and does not address the required checks of the SCDHHS Program Integrity website. *Policy EP302, OIG/GSA Screening* is an Anthem Corporate policy and does not address requirements specific to SC exclusion status monitoring. The policy states associates, the Board of Directors, ≥5% shareholders, independent (non-associate) board members of wholly owned subsidiaries, subcontractors, vendors, agents, brokers, providers, and First Tier, Downstream and Related Entities (FDRs) are screened against the Office of Inspector General's List of Excluded Individuals/Entities and the General Services Administration's System for Award Management. Screening is performed after an offer of employment is accepted and prior to the first day of employment, or prior to engagement or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						contracting, and then monthly thereafter. The policy does not address the requirement to query the Social Security Administration's Death Master File or the requirement to monitor the SCDHHS Program Integrity databases, which include: •Social Security Death Master File •SC List of Excluded Providers •SC List of Providers Terminated for Cause •Suspensions List •Behavioral Health Actions List During onsite discussion, staff revealed the SCDHHS Program Integrity databases are monitored at least monthly. *Quality Improvement Plan: Update the Compliance Plan and Policy EP302 to include all queries required for exclusion status monitoring for South Carolina, as the SCDHHS Contract, Sections 11.2.10 through 11.2.11.1 require. This can be accomplished via an addendum to the respective document.*
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Committee oversees, monitors, and assesses the effectiveness of the Compliance Program. The Committee meets quarterly with additional meetings as needed, and the quorum is defined as 3 committee members from each organization (Amerigroup and BlueChoice). In the absence of a quorum, the committee will not vote or address new motions and all items requiring a vote or motion will be pended until the next regular meeting. The Compliance Committee's membership is documented in the *Compliance Committee Charter*, the *2019 Quality Management Program*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description, and in the *Healthy Blue Committee List* document. However, the *Healthy Blue Committee List* for the Medicaid Compliance Committee includes 1 member (Growth Director Medicaid Alliance) who is not included in the other documents. Onsite discussion confirmed the Growth Director Medicaid Alliance is not a member of the Compliance Committee. *Recommendation: Revise the Compliance Committee's membership in the Healthy Blue Committee List to reflect current membership of the committee.*
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The *Antifraud Plan* and related policies define activities to prevent and detect FWA, including, but not limited to, claims edits, internal audits, pre- and post-payment reviews, utilization management protocols, and data mining.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Ethics and Compliance Departments, along with Human Resources, conduct internal investigations of allegations of wrongdoing by employees. The Special Investigations Unit (SIU) may assist when requested. The SIU conducts investigations of known or suspected fraud or abuse by network providers or members. The SIU also maintains routine contact with vendors (pharmacy, dental, vision, etc.) about their FWA activities and works with vendors as needed to investigate providers in their networks. The investigative process is detailed in the *Antifraud Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Details about the program established to meet the requirement for a pharmacy lock-in program are found in *Policy SC_PMXX_025, Medicaid Pharmacy Lock-In Program*. As documented in the policy, the program is compliant with all contractual requirements.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					*Policy MCD-09, Privacy and Confidentiality* states new employees, consultants, and contractors must attend *Our Values* training which includes an overview of HIPAA, defines protected health information (PHI), and defines impermissible uses or disclosures of PHI. The policy indicates all new employees must complete this training before any access to PHI is granted.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				The *Healthy Blue Credentialing Program Plan* gives an overview of the credentialing program and several policies address the processes for initial and recredentialing. While the program and policies are comprehensive, they do not address all the queries required by SCDHHS Program Integrity. The following issues were identified: •The *Healthy Blue Credentialing Program Plan Sections VI A, VI B,* and *VII* do not include the Suspended List or Behavioral Health Actions list as required queries. •*Policy MCD-04, Initial Credentialing* does not include the Suspended List or Behavioral Health Actions list as required queries. •Page 6 of *Policy MCD-04* references *Policy MCD-02, Medical Office Pre-Contracting Site Review* which is no longer an active policy. • *Policy MCD-05, Recredentialing* does not include the Suspended List or Behavioral Health Actions list as required queries. *Quality Improvement Plan: Update the Healthy Blue Credentialing Program Plan and Policies MCD-04 and MCD-05 to include the Suspended List and Behavioral Health Actions List as required queries. For Policy MCD-04, remove the reference to retired Policy MCD-02.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Credentialing Committee has the responsibility for direction of the credentialing program and activities of credentialing potential network providers and facilities. The committee is chaired by Dr. Lloyd Kapp, Medical Director, with additional members including the Vice President of Medical Affairs and nine network providers. The specialties represented include internal medicine, pediatrics, chiropractic, surgery, pulmonology, OB/GYN, dental, nurse practitioner and certified family nurse practitioner. Only the external committee members have voting privileges and at least three external voting committee members must be represented to constitute a quorum. A review of committee minutes showed the quorum was met. BlueChoice conducts the credentialing process for behavioral health providers; however, the Companion Benefit Alternatives (CBA) Credentialing Committee conducts credentialing approval activities related to behavioral health.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files are organized, and for the most part contain appropriate documentation. Any issues are discussed in the respective section.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list and the CMS Adverse Action Report List;		X				SCDHHS Program Integrity requires query of the following lists: SC Excluded Provider List, Suspended List, Terminated for Cause List, and Behavioral Health Actions List. None of the credentialing files reviewed contained proof of query of the Suspended List or the Behavioral Health Actions List. *Quality Improvement Plan: Ensure credentialing files contain proof of all queries required by SCDHHS Program Integrity.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files are organized and obtain most of the appropriate documentation. Any issues are discussed in the respective section.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List;		X				SCDHHS Program Integrity requires query of the following lists: SC Excluded Provider List, Suspended List, Terminated for Cause List, and Behavioral Health Actions List. None of the recredentialing files reviewed contained proof of query of the Suspended List or the Behavioral Health Actions List. *Quality Improvement Plan: Ensure recredentialing files contain proof of all queries SCDHHS Program Integrity requires.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					Provider profiling information regarding sanctions, member complaints and quality issues are considered in the recredentialing process. BlueChoice uses provider performance reports such as the monthly *Gaps in Care Report*; *Membership Loss Ratio by Practice*; monthly *ER Diversion Report*; and *HEDIS Measures* reports to educate providers.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					*Policy SC_GAXX_022, Processing Internal Potential Quality Issues* and *Policy SC_GAXX_021, Clinical Quality Incident Severity Level Determination* address identifying, investigating, and reviewing potential quality of care and preventable adverse events that arise in relation to contracted practitioners, groups, or institutions. *Policy MCD-07, Professional Practitioner - Restriction, Suspension or Termination* states the Credentialing Committee or Medical Director reserves the right to restrict, suspend or terminate participating providers based on issues of quality of care, federal sanction, or failure to meet credentialing standards. Providers are offered appeal rights, and outcomes of investigations are reported to appropriate outside agencies.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The process to evaluate health care delivery organizations for approval in to the BlueChoice or CBA network is addressed in *Policy MCD-06, Health Care Delivery Organizations - Credentialing/ Recredentialing*. The "Queries Performed" section of the policy does not address all the queries required by SCDHHS Program Integrity such as the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Termination for Cause List, the Suspended List, and the Behavioral Health Actions List. CCME's review of the organizational files reflect appropriate documentation except for proof of query of the Suspended List, and the Behavioral Health Actions List. Proof of the Terminated for Cause List was received in the files reviewed. *Quality Improvement Plan: Update the "Queries Performed" section of Policy MCD-06, Health Care Delivery Organizations – Credentialing/ Recredentialing to reflect the following queries: Termination for Cause List, Suspended List, and Behavioral Health Actions List. Ensure organizational credentialing and recredentialing files contain proof of query of the Suspended List and the Behavioral Health Actions List.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				*Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination* states BlueChoice Credentialing has a process to monitor provider sanctions on an ongoing basis. State and Federal sources are queried monthly. Page 2 (#1) lists various state and licensing/ reporting sources used to identify providers who warrant investigation. The list includes the SC Excluded Provider List and the Terminated for Cause List but does not include the other two lists required by SCDHHS Program Integrity: the Suspended List and the Behavioral Health Actions List. Verified sanction information is presented to the Credentialing Committee to determine if there is a need to restrict, suspend, or terminate a provider from the network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC_PNXX_309, Excluded and Debarred Providers addresses excluded and debarred providers, but the policy does not include all query lists SCDHHS Program Integrity requires: the Suspended List and the Behavioral Health Actions List. *Quality Improvement Plan: Update Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination and Policy SC_PNXX_309, Excluded and Debarred Providers to include the following lists SCDHHS Program Integrity requires: the Suspended List and the Behavioral Health Actions List.*
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Provider access standards that comply with contract guidelines are defined in *Policy MCD-11, Medicaid Access/Availability Standard*. Primary care providers (PCPs) are measured as one PCP within 30 miles for 95% of the population. The number of PCPs accepting new patients per number of members is measured as one PCP per 2,500 members. *GeoAccess* reports and *Network Analysis* reports show that 100% of members have access to their PCP. Onsite discussion confirmed *GeoAccess* reports are used internally to assess network gaps.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *BlueChoice HealthPlan of South Carolina 2018 Medicaid Availability Analysis, Primary Care Physicians & High Volume Specialists Report* shows 100% of members have access to their PCPs within the 30-mile access standard and the provider-to-member ratio was 80.0 PCPs per 2,500 members.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					The access standard for specialists (including hospitals) is measured as one specialist within 50 miles for 95% of the population as defined in *Policy MCD-11, Medicaid Access/Availability Standard*. Pharmacies are measured as one with 30 miles for 95% of the population. The number of specialists accepting new patients per number of members is measured as one specialist per 3,000 members. *Policy MCD-11* does not address the drive time requirements for measuring provider access as specified in the *SCDHHS Policy and Procedure Guide, Section 6.2* . Onsite discussion confirmed the plan considers drive time when measuring provider access. *GeoAccess* reports that comply with contract guidelines were received for various specialties. The *BlueChoice HealthPlan of South Carolina 2018 Medicaid Availability Analysis, Primary Care Physicians & High Volume Specialists Report* shows 100% of members have access to high volume/high impact specialists within the 50-mile access standard and the provider-to-member ratio exceeded the defined standard for the various specialties. *Recommendation: Update Policy MCD-11, Medicaid Access/Availability Standard to include*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the drive time requirements as defined in the SCDHHS Policy and Procedure Guide, Section 6.2.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					BlueChoice submits bi-annual network reports to SCDHHS as defined in *Policy MCD-11, Medicaid Access/Availability Standard.*
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The *Provider Manual* details information regarding cultural diversity and linguistic services. BlueChoice developed a "Caring for Diverse Populations" toolkit to give providers specific tools for breaking through cultural and language barriers to better communicate with their patients. The toolkit, as well as cultural competency training, is available on the website. *Policy SC_CLLS_018, Cultural and Linguistic Program* defines the cultural linguistics program and states interpreter services for health-related services are provided to members at no cost and are available 24-hours a day, seven days a week. BlueChoice assesses the cultural and linguistic needs of members to ensure sufficient providers are available to meet the membership needs.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					The online searchable *Provider Directory* is detailed and user friendly. The online *Provider Directory* is updated weekly and paper copies are printed by a Customer Service Representative upon a member's request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						It was noted the online *Provider Directory* and the printed copy received in the desk materials does not address handicap access. When questioned as to how a member would know if a provider was handicap accessible, the plan indicated that adding that feature was currently in the works. *Recommendation: Ensure the Provider Directory addresses the provider's ability to accommodate individuals with physical disabilities.*
3.Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Physician office accessibility standards are defined in *Policy MCD-11, Medicaid Access/Availability Standards*, and behavioral health access standards are defined in *CBA Policy PN001, Access/ Availability Standards for CBA Network*. The general appointment and behavioral health appointment standards are listed in the *Provider Manual*. BlueChoice measures provider accessibility through evaluating results of *Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* questions relating to complaints/grievances and provider access. Results for the *2018 CAHPS Survey* questions were not yet available at the time of the onsite. BlueChoice also performs an after-hours survey to measure 24-hour provider access. Results of the survey conducted January 2019 showed a 97.47% compliance rate for 988 providers. Non-compliant providers will be trained and re-surveyed according to onsite discussion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						In 2018, BlueChoice attempted to conduct a physician office appointment access survey to measure adherence to routine and urgent appointment standards and wait time for emergency care. A total of 471 provider groups were selected and postcards were mailed with instructions to complete an online survey. Only three provider groups responded, which did not provide reliable data. BlueChoice is considering hiring a company to perform future surveys per onsite discussion. CBA also conducts a *Telephonic Provider Access Survey* to measure practitioner appointment availability and the 2019 draft report was received at onsite. Reported results appeared to meet the established goals for the access indicators except for practitioner accessibility within 10 working days for routine care. However, since the final data won't be reported until July/August 2019, it is unreliable. *Recommendation: Continue to monitor practitioner/provider appointment availability to ensure members have access to their providers within the defined timeframes.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			The results of the *Telephonic Provider Access Study* CCME conducted reflects calls were answered successfully 57% of the time (147 of 260) when omitting 33 calls answered by voicemail messaging services. When compared to last year's results of 69%, the decrease in successful answer rate was statistically significant (p=.004).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						For those not answered successfully (n=113 calls), 56 (50%) were unsuccessful because the provider was not at the office or phone number listed. One hundred and twenty-five (86%) of the providers indicated that they accept BlueChoice, and eight (5%) indicated this occurred only under certain conditions. Ninety-six of 130 (74%) responded that they are accepting new Medicaid patients. Regarding a screening process for new patients, 34 (37%) of the 92 providers responding to the item indicated an application or prescreen was necessary. Of the 34, 17 (50%) indicated an application must be filled out, whereas 6 (19%) require a review of medical records/immunizations before accepting a new patient, and 6 (19%) required both. When the office was asked about the next available routine appointment, 62 of the 70 that responded (89%) met contract requirements. Internal processes and information systems related to updating provider information should be reviewed to ensure contact information for providers is updated in a timely and accurate manner. During the onsite it was mentioned that two primary methods are used to ensure accuracy: MD Checkup (a web-based tool that requires providers to verify their contact information) and claims volume assessments. CCME suggested BlueChoice create a policy or document that explains the methods used to ensure accuracy of the provider network contact information. *Quality Improvement Plan: Internal processes and information systems related to updating provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information should be reviewed to ensure contact information for providers is updated in a timely manner and accurate. Create a policy or document that explains the methods used to ensure accuracy of the provider contact information for the BlueChoice provider network.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					The Healthy Blue Provider Education Department conducts onsite educational sessions for new providers when the contract is signed. The new provider orientation training covers various topics such as provider responsibilities, access and availability standards, Fraud, Waste and Abuse and the False Claims Act, covered benefits, etc. as defined in *Policy MCD-01, Education of Contracting Providers*.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing provider education includes individual onsite visits, annual educational workshops, website, newsletters, and the *Provider Manual*.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Preventive health guidelines are reviewed annually, whenever pertinent, or when new evidence is available as defined in *Policy SC_PCXX_006, Preventive Care*. After review and approval by regulatory and legal areas, the proposed recommendations are sent to the Clinical Quality Improvement Committee for approval and adoption prior to publication on the website.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive health guidelines are posted to the member and provider website and addressed in the *Provider Manual*. Newly contracted providers are informed of the preventive health guidelines through their welcome materials. Printed copies are available upon request.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					BlueChoice adopts nationally recognized clinical practice guidelines (CPGs) for asthma, diabetes, hypertension and other conditions. The process of adoption, review and approval of CPGs for medical and behavioral health is addressed in *Policy SC QMXX-048, Clinical Practice Guidelines Review, Adoption, and Distribution*. The CQIC reviews and adopts the CPGs as updates are made.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					Providers are educated about the CPGs through information in the *Provider Manual* and all guidelines are loaded to the website. A review of the guidelines revealed the web link for the Celiac Disease CPG does not work. *Recommendation: Correct the link for the Celiac Disease CPG on the website.*
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					The *Provider Manual* states the PCP maintains frequent communication with the specialist physician, hospital and/or ancillary provider to ensure continuity of care. *Policy SC QMXX-080, Monitoring Continuity and Coordination of Medical Care* defines the process for the plan to collect

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and analyze data to identify opportunities and assess coordination of medical care. This includes identifying opportunities to collaborate between medical and behavioral healthcare practitioners. This process is completed annually.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					*Policy SC_QMXX_105, Medical Record Review* states the Clinical Quality Department staff conducts Medical Record Compliance Audit (MRCA) reviews on providers annually until they achieve a score of 80% or higher. All offices receive initial feedback in writing after the record audit visit. Offices that score below 90% on any category receive education related to the identified deficiencies. The overall performance standard is a cumulative score of 80%. Sites scoring below the 80% cumulative score are mailed a score letter explaining their deficiencies. A corrective action plan is developed, and a follow-up visit is conducted within 6 months.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Results of the 2018 Medical Record Compliance Audit shows 42 practices with 65 providers were audited for a total of 302 medical records. All the practices audited (100%) achieved a score of >90% so corrective action was not needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					BlueChoice guarantees member rights and responsibilities as outlined in *Policy SC_ QMXX_104, Member Rights and Responsibilities*.
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately listed in the *Evidence of Coverage*, *Provider Manual*, and on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					*Policy SC_COXX_126, Annual Notification to Members,* notes new members will receive a New Member Kit, which contains a welcome letter and the *Evidence of Coverage*. CCME could not identify the timeframe within which new members are informed of all benefit information. Onsite discussions confirmed *Evidence of Coverage* and Member ID Cards are issued to new members according to the *SCDHHS Contract* timeframe requirements. Additionally, staff reported the *Evidence of Coverage* is issued within 5 business of a request by a member and the *Provider Directory* is issued within 48 hours. The *Evidence of Coverage* informs pregnant women SCDHHS will enroll the baby on the mother's plan during the baby's birth month. BlueChoice documents changes to the *Evidence of Coverage* on a change control record which is posted on the website. *Recommendation: Consider editing Policy SC_COXX_126, Annual Notification to Members to include timeframes for the provision of new member materials. Refer to the SCDHHS Contract, Section 3.14.3. Also consider adding that paper copies of member information are provided within 5 business days, without charge, upon request, as confirmed during the onsite. Refer to the SCDHHS Contract, Section, 3.13.1.5.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Benefits and services included and excluded in coverage;						A table of covered services, with limits and exclusions, is located on page 12 of the *Evidence of Coverage*, and benefit information is noted throughout the handbook. The member website is user-friendly allowing members to easily obtain information.
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						Information regarding copayments and members who are required to pay a copayment is clearly described in the *Evidence of Coverage*, *Provider Manual*, and the website.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						
1.7 Policies and procedures for accessing specialty care;						*Policy SC_UMXX_003, Access to Specialty Care* and page 31 of the *Evidence of Coverage* describe requirements for obtaining specialty care or treatment from a specialist.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						BlueChoice notifies members by mail of changes to the provider network, benefits, and services no later than 30 days prior to implementation, as described in *Policy SC_PNXX_303, Provider Termination and Member Notification*, and noted in the *Evidence of Coverage*. Updates to the *Preferred Drug List* (PDL), including negative changes, are accessible on the website 30 days prior to the effective date as noted on page 93 of *Policy A16, Health Plan Pharmacy Benefits*. The website has a hyperlink titled "PDL" for the *Preferred Drug List* and a hyperlink titled "Pharmacy Formulary Change Notice" for the PDL updates. Since the term "formulary" is neither explained nor defined on the Pharmacy Information page of the member's website, members may not understand that it is referring to the PDL. *Recommendation: Edit the Pharmacy Information page of the member's website to define the term "formulary" or replace it with the term "PDL."*
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The *Evidence of Coverage* informs members to contact Member Services or use the *Provider Directory* to select a Primary Care Physician (PCP) and obtain information about the PCP's age restrictions, gender, hospital affiliation, language spoken, and address. A searchable *Provider Directory* is available on the website or members can request a paper copy.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						The *Evidence of Coverage* indicates BlueChoice provides free interpreter and translation services to members who speak other languages, require sign language or have limited English. Written materials in alternative formats, such as large print or simple language, can be obtained by calling the Customer Care Center (CCC) or emailing or GBD.Interpret@amerigroup.com.
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The *Evidence of Coverage* provides appropriate toll-free phone numbers for the CCC, the 24-Hour Nurse Advice Line, and SCDHHS. Additionally, toll-free numbers with descriptions are listed for pharmacy, behavioral health, vision and dental services. Members can contact BlueChoice through secure email by logging into the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						www.HealthyBlueSC.com member portal. Additionally, contact information is located on the member website with the ability to use Skype.
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						A description of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Well-Child services is included in the *Evidence of Coverage* and the *Provider Manual*. Members are instructed to access the website for a summary of the *Preventive Health Guidelines* with the recommended age-appropriate screenings, treatments, and immunizations, or they can request a copy. The age requirement for EPSDT/Well-Child services are for children through the month of their 21st birthday.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						Page 70 of the *Evidence of Coverage* describes and defines Advanced Directives and Living Wills and instructs members to contact the Lieutenant Governor's Office on Aging in SC to obtain applicable forms. *Policy SC_QMXX_074, Advance Directives* indicates members who are at least 18 years of age have the right to execute an Advance Directive in writing. Page 3 of the policy provides an incorrect link for staff to instruct members to obtain information. Once accessed, the link directs you to a site to search for services for seniors, care givers, and adults with disabilities. CCME could not identify Advance Directive information on this site.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit Policy SC_QMXX_074, Advance Directives with a correct link to obtain Advanced Directive forms or remove the link from the policy.
1.21 Information on how to report suspected fraud or abuse;						Fraud, Waste and Abuse (FWA) is appropriately defined in the *Evidence of Coverage* and the website. Instructions are provided for members to anonymously report FWA to BlueChoice, SCDHHS, and to SC Attorney General Medicaid Fraud Unit.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Page 2 of *Policy SC_COXX_126, Annual Notification to Members* indicates the *Evidence of Coverage* and Annual Newsletter inform members of their right to request an *Evidence of Coverage* and *Provider Directory* at least once per year. CCME could not identify where this is communicated to the member. During the onsite visit, staff confirmed members are notified of this right in a one-page letter and this information is not included in the *Evidence of Coverage* or Annual Newsletter. *Recommendation: Edit Policy SC_COXX_126, Annual Notification to Members to indicate members are notified annually in writing of their right to request an Evidence of Coverage or a Provider Directory once each year. Additionally, either remove language that members are informed of this right in the Evidence of Coverage and Annual Newsletter from the policy or include the appropriate language in the Evidence of Coverage and Annual Newsletter.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					BlueChoice notifies members by mail of significant changes in benefits, rights and responsibilities, 30 days prior to the effective date and within 15 days after a provider's termination notice is received as described in *Policy, SC_COXX_126 Annual Notification to Members* and *Policy, SC_PNXX_303, Provider Termination and Member Notification*.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					*Policy SC_MKXX_012, Member Materials Development and Translations* confirms member materials are written at no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. Materials are written using a minimum 12-point font. When 5% or more of the resident population of a county is non-English speaking and speaks a specific language, materials are made available in the respective language.
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					*Policy SC_CSPC_002, Customer Service*, states "members may contact the CCC through a dedicated toll-free number from 8:00 AM to 6:00 PM Eastern Standard Time, Monday through Friday excluding state holidays." The CCC monitors and tracks call volumes to ensure performance standards are achieved and has established criteria for measuring the quality and accuracy of information provided to members. The toll-free telephone number for CCC and the 24-Hour Nurse Advice Line are located on the member's ID card, in the *Evidence of Coverage*, and on the BlueChoice website. Additionally, this information is in education materials such as the *2018 Annual Member Newsletter*.
III C. Member Enrollment and Disenrollment						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					*Policy SC_UMXX_125, Termination of Membership,* defines the process for member disenrollment initiated by BlueChoice or SCDHHS. BlueChoice must request member disenrollment in a writing to SCDHHS and requests cannot be due to a change in health status, utilization of services, or diminished mental capacity.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					BlueChoice refers members to the website or *Evidence of Coverage* for information on scheduled preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services. *Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution* and *Performance Monitoring* and *Policy SC_HEXX_006, Delivery of Health Education Programs and Services* describe the process and methodology to encourage and inform members to use the services, such as member newsletters, targeted mailings, and health management programs.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					BlueChoice ensures the provision of screening, preventive, and medically necessary diagnostic and treatment services for members through the month of their 21st birthday as stated in *Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services*. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy describes processes and methods for notification, tracking, and follow-up of the EPSDT program and addresses barriers of low utilization by creating interventions to encourage members to use the services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					BlueChoice tracks timeliness of prenatal care by Healthcare Effectiveness Data Information Set (HEDIS) monitoring of pregnant members, as reported in the *2018 QM Evaluation*. The *Evidence of Coverage* describes pregnancy programs for women to receive education on services that can assist in achieving a healthy pregnancy, such as the New Baby, New Life℠ program, Centering Pregnancy services and the My Advocate® smartphone app.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					BlueChoice contracts with DSS Research, a certified *Consumer Assessment of Healthcare Providers System (CAHPS) Survey* vendor, to conduct the *Adult* and *Child Surveys*. The actual sample sizes were adequate and met the National Committee for Quality Assurance (NCQA) minimum sample size and number of valid surveys (at least 411), but the response rates were below the NCQA target of 40%. For adults, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						response rate was 26.8% (n=465 completed surveys) which is above the 2017 national average of 23.3%; For child, the response rate was 23.31% (above the national rate of 22.3% but below the target rate of 40% (n=497 completed surveys). The number of completed surveys for the total population in the *Children With Chronic Conditions Surveys* was 964, with a response rate of 24.33% which is above the national average in 2017 of 22.3%, but below the NCQA target. During the onsite discussion, it was noted that CCC call scripts and a CAHPS banner on the website are used to increase member awareness of the survey and to increase response rates. *Recommendation: In addition to the other interventions that are in progress, continue working with DSS Research to increase response rates for Adult and Child surveys.*
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					DSS Research summarizes and details all results from both surveys. The analysis and implementation of interventions to improve member satisfaction is conducted by the Quality Improvement Committees. Documentation regarding the committee meetings and analysis was submitted in the desk materials. The *QI Evaluation* displayed an analysis of data and action steps to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The Clinical Quality Improvement Committee (CQIC) minutes from October 30, 2018 and Service Quality Improvement Committee (SQIC) minutes from November 16, 2018 indicated results were presented and action plans were initiated to address problematic survey measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Survey results were offered to providers in the *CAHPS Results Provider Notification Letter*.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The CAHPS Outcome report was presented to the CQIC on October 30, 2018 and to the SQIC on November 16, 2018.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
contract requirements, including, but not limited to:						
1.1 The definition of a grievance and who may file a grievance;	X					The definition of a grievance and who may file a grievance is appropriately documented in *Policy SC_GAXX_015, Grievance Process: Members*, the *Evidence of Coverage*, and *Provider Manual*.
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;		X				*Policy SC_GAXX_015, Grievance Process: Members* indicates BlueChoice resolves grievances and provides notice within 30 days of receiving the grievance. However, the *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment state grievances are resolved within 90 calendar days from the date of receipt. During the onsite, staff confirmed grievances are resolved within 30 calendar days. BlueChoice was reminded that documentation of incorrect resolution timeframes was identified as a deficiency during the 2018 EQR. Grievances are extended up to 14 calendar days when requested by the member or BlueChoice. However, *Policy SC_GAXX_015, Grievance Process: Members* does not indicate the MCO must make reasonable efforts to give the member prompt oral notice of the delay and within 2 calendar days give the member written notice of the reason, as *SCDHHS Contract, Section 9.1.6.1.5* requires. *Quality Improvement Plan: Revise the Grievance Acknowledgement Letter and the Your Grievance and Appeal Rights as a Member of BlueChoice*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						HealthPlan Medicaid letter attachment to reflect grievances are resolved within 30 calendar days of receipt. Edit Policy SC_GAXX_015, Grievance Process: Members, to include the complete SCDHHS Contract requirements in Section 9.1.6.1.5.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.		X				Page 8, Section R of *Policy SC_GAXX_015, Grievance Process: Members* indicates grievance logs and grievance records are retained for 5 years and states, "Electronic files are maintained for longer than 5 years." However, the *Anthem Record Retention Schedule* indicates records are kept for 10 years. Onsite discussions confirmed BlueChoice follows Anthem's record retention policy and maintains grievance logs and records for a minimum of 10 years. BlueChoice was reminded that documentation of incorrect record retention timeframes was identified as a deficiency during the 2018 EQR. *Quality Improvement Plan: Edit Policy SC_GAXX_015, Grievance Process: Members, to include grievance logs and records are maintained for a minimum of 10 years as the SCDHHS Contract, Section 19.35.3 requires.*
2. The MCO applies grievance policies and procedures as formulated.	X					Review of grievance files indicate member grievances are acknowledged and resolved within the required timeframe. Staff consistently performed HIPAA verification and addressed gaps in care and preventive health measures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					BlueChoice tracks and trends member grievances and prepares quarterly reports for the SQIC where barriers, interventions and risks are discussed. Minutes indicate the timeliness goal of 98% was not met for Q4 2018 and the top grievance categories are related to providers billing members.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					BlueChoice's *2019 Medicaid Quality Management Program Description* describes the program's quality improvement (QI) structure, function, scope, and goals as defined by the health plan. BlueChoice's Medicaid Board of Directors (BOD) has ultimate authority and accountability for the QI Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					The *2019 Medicaid Quality Management Program Description* includes information regarding the adoption of clinical practice and preventive health guidelines. *Policy SC_QMXX_048, Clinical Practice Guidelines – Review, Adoption and Distribution* discusses monitoring provider compliance with the guidelines. This policy mentions provider compliance is assessed through medical record audits, monitoring utilization data, and HEDIS performance gap-in-care data. Reports of the monitoring were not found in the desk materials. This was discussed during the onsite and staff indicated the monitoring was conducted during the medical record audits. A copy of the audit tool and results was provided.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					BlueChoice maintains an annual QI work plan that provides ongoing progress on QI activities throughout the year. The work plan is updated regularly and presented to the Service Quality Improvement Committee (SQIC) and the Clinical Quality Improvement Committee (CQIC) for review and approval. BlueChoice provided the 2018 and 2019 work plans for this review.
IV B. Quality Improvement Committee						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Per the *2019 Medicaid Quality Management Program Descriptions*, BlueChoice's CQIC and SQIC are responsible for the implementation and oversight of the QI program. These committees review data to ensure performance meets standards and makes recommendations for improvements.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Associate Medical Director chairs the CQIC and membership includes contracted primary and specialty care physicians. The specialties of the contracted providers include family medicine, pediatrics, OB-GYN, and emergency medicine. A behavioral health Medical Director is included as a member of the committee; however, a contracted behavioral health provider is not included. *Recommendation: Include a contracted behavioral health provider as a member of the CQIC.*
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					BlueChoice uses Inovalon, a certified software organization, for calculation of HEDIS rates and the validation found all requirements were met. The comparison from the previous to the current year revealed a substantial improvement (>10%) in Immunizations for Adolescents – HPV, Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence for 13-17 year-olds, Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5 year-olds, and Psychosocial Care for Children and Adolescents on Antipsychotics for 12-17 year-olds and the overall Total Rate. The measures that decreased were Diabetes Monitoring for People With Diabetes and Schizophrenia and Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					BlueChoice submitted three projects. They included Access and Availability of Care, Childhood Immunizations Combo 3 and Lead Screenings, and Comprehensive Diabetes Care.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The Childhood Immunizations Combo 3 and Lead Screenings project was noted as retired and the Comprehensive Diabetes Care was a new project. The documentation received for the Comprehensive Diabetes Care project found missing data. This was

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussed during the onsite. BlueChoice provided a brief summary of the results and analysis. CCME combined the performance improvement project (PIP) report and brief summary for validation. Both projects received a score within the "High Confidence in Reported Results" level. Details of the validation of the PIPs can be found in the *CCME EQR Validation Worksheets, Attachment* 3.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *2018 Quality Management Program Work Plan Annual Evaluation* was provided. Because the program evaluation was a draft, the SQIC and the CQIC neither reviewed nor approved it. Staff indicated they were in the process of completing the evaluation and will be submitting the document to the committees. There appeared to be sections of the document that contained incorrect or incomplete information. For example, on page 26 of the Quality of Care Review section, the wrong definition of a grievance was used.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The data indicated there were 4 grievances related to Quality of Care. However, the analysis did not address Quality of Care. Tables on page 30 seemed out of place. Page 75 references a table that was missing. In the Clinical Quality Improvement Activities section, only the Effectiveness of Care Measures are displayed. On pages 106 – 112 of the PIP section, there is no mention of the Childhood Immunizations Combo 3 and Lead Screenings PIPs. *Recommendation: Ensure the documentation is complete and accurate in the QI Program Annual Evaluation.*
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					BlueChoice partners with Amerigroup to administer the utilization management activities for its Medicaid line of business. Departments within Amerigroup's Health Care Management (HCM) Division include Behavioral Health (BH), Case Management (CM), Physical Health Utilization Management, Disease Management Centralized Care Unit (DMCCU), Maternal-Child Services, Pharmacy Management, and Clinical Quality Management. The *Utilization Management (UM) Program Description* is specific to the South Carolina Medicaid line of business and includes the program's purpose, scope, objectives, structure, staff qualifications and responsibilities, and describes key aspects of the UM Program. Separate policies provide additional detail on specific UM processes and requirements.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					Lines of responsibility and accountability are addressed in the *UM Program Description* and displayed on the Organizational Chart.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				Timeliness guidelines for UM determinations are documented in the *UM Program Description, Policy SC_UMXX_117, Decision and Notification Timeframes*, the *Evidence of Coverage*, the *Provider Manual*, and *Policy A16, Health Plan Pharmacy Benefits, Exhibit P (SC Pharmacy Services)*. The *SCDHHS Contract, Section 8.6.1.3* and *42 CFR § 438.210 (d) (1)* allow 14 days for a determination with a possible extension of 14 additional days under specific circumstances. The maximum amount of time allowed for a standard authorization with an extension is 28 calendar days from the date of receipt of the authorization request. Issues identified include: •Page 21 of the *UM Program Description* indicates for plan-initiated extensions of standard (non-urgent) authorization timeframes due to insufficient clinical information, members (or member representatives) are given 45 calendar days to provide the needed information. •The *UM Program Description* also states the extension period, within which a decision must be made by the plan, begins on the date the organization receives the member's response (even if not all the information is provided), or at the end of the time period given to the member to supply the information if no response is received.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						While reviewing documentation related to authorization determination timeliness, CCME identified the following statement on BlueChoice's website: "Services requiring prior authorization (PA) for BlueChoice HealthPlan Medicaid members enrolled in the Healthy Connections program can be found by viewing the PA grid on our website." CCME was unable to locate the referenced PA grid on the website. *Quality Improvement Plan: Revise page 21 of the UM Program Description to reflect correct information about the amount of time members/representatives can submit clinical information when a plan-initiated extension has been implemented and when the time period for the extension begins.* *Recommendation: Revise the website (Home > Providers > Prior Authorization and Claims) to include the referenced PA grid or remove the reference from the website.*
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					No incentives or rewards are given to staff, providers, and others for decisions that result in underutilization or that create barriers to care and service. *Policy SC_UMXX_065, Separation of Financial and Medical Necessity Decision-Making*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						confirms UM decisions are not based on financial incentives and states peer reviewer contracts do not include language that any financial reimbursement is based on decisions made by the reviewer. The policy further states that contracted peer reviewers identified as having a conflict of interest or discovered to be receiving any incentive that may affect review decisions are terminated.
1.7 the mechanism to provide for a preferred provider program.	X					BlueChoice's Preferred Provider Program has been in effect since December 2016 and offers providers an opportunity to earn Gold Card status for the prior authorization process. The program is open to Ear, Nose, and Throat specialists (ENTs), Pain Management specialists, Gastroenterologists, and Orthopedists. Criteria for program eligibility include a 94% approval rate for highly used codes, indicating the provider follows medically necessary criteria and provides appropriate, high quality service. The codes and providers are evaluated annually for amendment, and Gold Card providers are audited annually to determine continued eligibility for the program. Information about the Preferred Provider Program is included in the *Provider Manual*.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated annually. Documentation of the evaluation includes identified barriers to expected outcomes and establishment of a work plan (with a schedule of activities, measurable objectives, and continuous monitoring of previously identified issues along with the effectiveness of UM services), routine monitoring and evaluation of target metrics and benchmarks, and a population analysis to identify gaps in services, programs, educational materials, and network providers. The *2018 Utilization and Case Management Program Annual Evaluation* was approved by the Clinical Quality Improvement Committee (CQIC) on 4/17/19 and includes information about program accomplishments, opportunities, and performance summaries, an evaluation of program structure effectiveness, and an evaluation of program activity related to UM, over- and under-utilization, inter-rater reliability (IRR), member and provider satisfaction with UM, member satisfaction with CM, audits of UM and CM, a summary of readmission prevention activities, and activities related to prevention of unnecessary emergency room utilization. It concludes with recommendations for the next calendar year.
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Medical necessity reviews are conducted primarily using MCG™ Guidelines along with medical policies, clinical UM guidelines, and AIM Specialty Health® guidelines (for diagnostic imaging requests, such as high tech radiology, sleep studies, radiation oncology, cardiology diagnostics and musculoskeletal diagnostics and treatment). Behavioral health medical necessity reviews are conducted primarily using Amerigroup medical policies, American Society of Addiction Medicine (ASAM) criteria, and Amerigroup clinical UM guidelines for behavioral health services.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					CCME's review of UM approval files confirmed appropriate medical necessity criteria were applied and relevant clinical information was requested when needed.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					*Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies* details requirements for coverage of these procedures. Requirements are also found in the *Provider Manual*, and member-appropriate information is found in the *Evidence of Coverage*. Page 2 of *Policy SC_UMXX_129* states that for sterilization requests, the *Surgical Justification Review for Hysterectomy* form is required along with the signed *Consent for Sterilization* form (HHS -687). This requirement is also stated on page 63 of the *Provider Manual*. Onsite discussion confirmed this is an error and sterilization requests do not require submission of the *Surgical Justification Review for Hysterectomy* form.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise Policy SC_UMXX_129 and the Provider Manual to remove the requirement for submission of the Surgical Justification Review for Hysterectomy form for sterilization authorization requests.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					As stated in the *UM Program Description*, established procedures are followed for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. This is reinforced in *Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria* which states "Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems." The policy continues to indicate the following factors are considered when applying medical necessity criteria: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					An annual IRR process is used to assess consistency in decision-making and adherence to company policies and processes by UM decision-makers. Physician and non-physician reviewers are included in the annual IRR process. Results are reported to the health plan and to the Chief Medical Officer/designated National Medical Directors, and the Quality Improvement Committees and/or Medical Operations Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Opportunities for improvement are identified and addressed by action plans which include re-education, re-testing, and auditing. *Policy SC_UMXX_120, Nurse Inter-Rater* defines IRR processes for non-physician licensed clinical staff who make UM decisions. The benchmark is 90%, and any score below the benchmark requires re-education, re-testing, and auditing. *Policy SC_UMXX_120, Physician Inter-rater Reliability Assessment* defines annual IRR processes for physician peer reviewers. The benchmark is established as 80%. Scores of less than 80% require an additional review of the assessment and concepts with the reviewer's manager to be documented.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Anthem's subsidiary, IngenioRx, Inc. manages the Anthem Pharmacy and Therapeutics Process. IngenioRx's Pharmacy and Therapeutics (P&T) Committee reviews drugs for efficacy, safety, effectiveness, etc. and the Value Assessment Committee (VAC) determines the formulary tier assignment or tier edits applied to covered medications. The Medicaid formulary is developed and managed in collaboration with the pharmacy benefits manager (Express Scripts). Anthem's Preferred Drug List (PDL) is a subset of the formulary and lists the preferred and/or non-preferred drugs within the most commonly

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						prescribed therapeutic categories. Both the PDL and the formulary are updated at least annually. Onsite discussion confirmed changes to the formulary/PDL are published at least 30 days in advance of the effective date on the website and written notice (via fax or letter) is provided to providers and affected members.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Processes are in place for medical necessity reviews for medications. Examples of when authorization is required include prescriptions that exceed established restrictions (such as age or quantity limits), prescriptions outside of FDA indications, etc. *Policy SC_PMXX_005, Provisional Drug Supply Management* details requirements for allowing a 72-hour supply of medications that require prior authorization. Onsite discussion confirmed that members with an urgent need for specialty pharmaceuticals can obtain the medication at a local pharmacy. The established process for provision of specialty pharmaceuticals is detailed in the *Provider Manual*.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					*Policy SC_UMXX_101, 24-hour Access to Emergency Department Services* describes requirements for coverage of emergency and post-stabilization services. Appropriate information is found in the *Evidence of Coverage* and *Provider Manual*.
8. Utilization management standards/criteria are available to providers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					UM approval files reflected that determinations and provider notification of the determinations met contractual timeliness requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files reflected appropriate attempts to obtain additional clinical information when needed to render a medical necessity determination.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					CCME reviewed 20 UM denial files and all were found to have timely determinations; however, two files were noted to have adverse benefit determination letters sent outside of the contractually required timeframes. *Recommendation: Ensure written notices of adverse benefit determination letters are sent within the contractually required timeframes. Refer to the SCDHHS Contract, Sections 8.6.1 and 8.6.2.*
V C. Appeals						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC_GAXX_051, Member Appeal Process defines processes and requirements for handling and resolving appeals.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Definitions of terminology and information about who can file an appeal are appropriately documented in *Policy SC_GAXX_051*, the *Evidence of Coverage*, and the *Provider Manual*. The BlueChoice website glossary uses the outdated term "action" instead of "adverse benefit determination." Also, the glossary's definition of an adverse benefit determination is incomplete—it is missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." Refer to the *SCDHHS Contract, Section 9.1 (b)* and *42 CFR § 438.400 (b)*. *Quality Improvement Plan: Revise the website glossary to use the current term of "adverse benefit determination" rather than "action" and to include the complete definition of an adverse benefit determination.*
1.2 The procedure for filing an appeal;		X				The *SCDHHS Contract, Section 9.1.1.2.2* allows 60 calendar days from the date on the adverse benefit determination notice to file an appeal. However, page 53 of the *Evidence of Coverage* incorrectly

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						states an appeal may be requested 60 calendar days from the date the notice is received. Most of the initial *Notice of Adverse Determination* letter templates submitted in the desk materials state appeals may be requested "within 60 calendar days from the date you receive this letter." The *Initial Denial – Not a Covered Benefit* letter and the *Your Grievance and Appeal Rights as a Member of Healthy Blue* state the timeframe as within 90 calendar days from the date the letter is received. However, the notice of adverse benefit determination letters in the UM denial files state the correct timeframe. Page 9 of *Policy SC_GAXX_051* incorrectly states the timeframe to request a State Fair Hearing as 30 calendar days from receipt of the appeal resolution notice. The *SCDHHS Contract, Section 9.1.6.3.1.1* allows 120 calendar days from the date of the notice of resolution to request a State Fair Hearing. *Quality Improvement Plan: Correct the timeframe to file an appeal on page 53 of the Evidence of Coverage. Correct the timeframe to request a State Fair Hearing on page 9 of Policy SC_GAXX_051.* *Recommendation: Review initial notice of adverse benefit determination letter templates and the Your Grievance and Appeal Rights as a Member of*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Healthy Blue letter attachment to ensure they reflect the correct appeal filing timeframe.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Timeliness requirements for appeal resolutions are documented in *Policy SC_GAXX_051*, the *Evidence of Coverage*, the *Provider Manual*, and elsewhere. Page 93 of the *Provider Manual* contains a discrepancy in documentation of the resolution timeframe for expedited appeals. It states both, "We resolve expedited appeals within 72 hours from the date Healthy Blue receives the request for an expedited appeal" and "We send a written resolution via certified mail within two calendar days from the date Healthy Blue receives the expedited appeal." Onsite discussion confirmed the expedited appeal resolution timeframe is within 72 hours of receipt of the appeal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Clarify the discrepancy in the expedited appeal resolution and notification timeframe on page 93 of the Provider Manual.
1.6 Written notice of the appeal resolution as required by the contract;	X					*Policy SC_GAXX_051* addresses requirements for appeal resolution notices.
1.7 Other requirements as specified in the contract.		X				Requirements for continuation of benefits pending the outcome of an appeal or State Fair Hearing are documented in *Policy SC_GAXX_051*, the *Evidence of Coverage*, and in the *Provider Manual*. Related to requests for continuation of benefits, the definition of "timely filing" on page 65 of the *Evidence of Coverage* is missing "The intended effective date of the MCO's proposed adverse benefit determination." Refer to the *SCDHHS Contract, Section 9.1.7.1.* Also, page 65 of the *Evidence of Coverage* documents the circumstances under which the health plan must continue the member's benefits and states, "You're still covered after we gave you our first approval." As written, this could be interpreted as referring to the member being covered by (or enrolled in) the health plan rather than the contractual requirement, "the original period covered by the original authorization has not expired." Refer to the *SCDHHS Contract, Section 9.1.7.2.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Correct the definition of timely filing related to requests for continuation of benefits on page 65 of the Evidence of Coverage to include the complete definition as stated in the SCDHHS Contract, Section 9.1.7.1. *Recommendation: Revise page 65 of the Evidence of Coverage to clarify they circumstances under which the plan must continue the member's benefits to indicate the originally approved authorization period for the services must not have expired. Refer to the SCDHHS Contract, Section 9.1.7.2.*
2. The MCO applies the appeal policies and procedures as formulated.	X					CCME reviewed 20 appeal files. Findings include: •The files reflect staff follow appropriate processes for receiving and acknowledging appeal requests. •The files reflected the appeal requests were routed to appropriate peer reviewers for determination. •All but one of the files was found to have the determination and notification within the required timeframes—the one untimely file was discussed during the onsite and staff reported this was an error in that the appeal request was not assigned to an appeal nurse resulting in the untimely determination and notification of the resolution. •Appeal resolution notices contain appropriate language and all contractually-required components. *Recommendation: Ensure appeals are appropriately assigned to appeal staff so that resolutions and notifications are compliant with contractual requirements.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Quarterly reports that track and trend member appeals are presented to the Service Quality Improvement Committee (SQIC). The SQIC reviews the appeals to identify and address trends. Review of SQIC minutes confirmed review and discussion of appeals metrics and data. Amerigroup performs monthly internal audits of appeal files to verify compliance with regulatory and accreditation requirements. Audit performance data is analyzed, and corrective actions are implemented for any issues identified.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					Case management, care coordination, and care transitions processes conducted by the plan are described in the *Case Management (CM) Program Description*, *Disease Management Program Description*, *Maternal Child Services Obstetrical and NICU Case Management Program Description*, and in departmental policies.
2. The MCO has processes to identify members who may benefit from case management.	X					Referrals for CM may come from both internal and external sources. BlueChoice uses the Chronic Illness Intensity Index (CI3) Report results from predictive modeling algorithms to identify opportunities for outreach, education, enhanced access, and care coordination. A risk score is assigned to all eligible members from sources such as claims and encounter

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						data, hospital discharge data, and UM and pharmacy data. In addition, the Likelihood of Inpatient Admission (LIPA) scale is used to further stratify specific members using a combination of utilization data (e.g. claims, encounter, authorization data), demographic factors, and diagnostic data to determine their likelihood of an inpatient admission within the next 60 days. *Policy GBD CM-019, Case Management Program Case Identification* and *Policy SC_CAXX_007, Care Management Targeting/Case Finding* provide detailed information about identification of members for CM services.
3. The MCO provides care management activities based on the member's risk stratification.	X					Initial stratification is assigned in various ways, including completion of the Health Risk Screening, predictive modeling, etc. *Policy GBD-CM-022, Case Management Caseload and Complexity Guidelines* defines the CM acuity levels which are assigned after completion of the clinical Health Risk Assessment and provides examples of interventions for each. The acuity levels include: •Low – Stable members following the plan of care •Medium – Members with well-coordinated services but a higher risk of exacerbation •High - Member's with unstable medical or psychosocial status who require frequent CM interventions •Severe – Members with severely unstable medical or psychosocial status with frequent admissions or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						readmissions and for whom the plan of care is not well-established •Complex/Catastrophic - Members with extremely unstable medical or psychosocial status and uncontrolled inpatient utilization along with inability to establish or coordinate the plan of care
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Transition of care activities and requirements are addressed in *Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care* and *Policy SC_CAXX_110, Case Management Transition and Continuity of Care: Current Provider Terminates with Plan*. Additionally, *Policy SC_CAXX_097, Transition to Other Care When Benefits End* addresses activities to ensure continuity of care when a member's benefits end and when transitioning from pediatric to adult care.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Onsite discussion confirmed Michael Brownlee, Manager, Case Management serves as the Transition Coordinator.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					BlueChoice evaluates member satisfaction with the CM Program by obtaining feedback using a telephonic member satisfaction survey process conducted by an external vendor. Members whose cases have been open for at least 60 consecutive days are eligible to participate in the survey. Survey results are reported to the Health Care Management Director for analysis and provided to the Quality Management Department for review, analysis, and submission to the Corporate Quality Management Committee. CCME's review of the SQIC minutes reflected quarterly reporting of the *CM Satisfaction Survey* results. From February 2018 to February 2019, satisfaction rates ranged from 91% to 95%.
7. Care management and coordination activities are conducted as required.	X					CCME reviewed 20 Case Management files. The files reflected appropriate assessment, monitoring, care plan development and revision, referrals and teaching to address barriers, and interventions to progress toward goals. Several files included case conference notes.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					*Policy SC UMXX 061, Under- and Over-Utilization of Services - Monitoring* is in place to ensure that BlueChoice monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization which may

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						impact health care services, coordination of care, and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					BlueChoice analyzes data on the following topics regarding utilization: •Emergency room visits •Frequency of selected procedures (back surgery, bariatric weight loss surgery, and tonsillectomy) BlueChoice analyzed and monitored utilization data and offered recommendations based on findings for the services indicated above. This was evident in committee minutes, in the 2018 *Utilization and Case Management Program Annual Evaluation*, and in the *2018 Under and Over Utilization* report.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					*Policy HP 003-12, Oversight of Delegated Activities* defines the process to ensure all delegated activities remain in compliance with the current delegation agreement and accreditation standards, and to identify mechanisms for corrective actions should noncompliance be identified. Activities may be delegated to certain organizations or vendors by Letter of Agreement or by Contract. The scope of such delegated activities is defined in a delegation agreement. While BlueChoice may delegate certain functions, it maintains responsibility and accountability for oversight of delegated activities, including pre-delegation activities, ongoing monitoring, evaluation, and actions to improve identified opportunities. BlueChoice's delegated services include: •Greenville Hospital System, Roper St. Francis Physicians Network, VSP, Medical University of South Carolina, South Carolina Department of Mental Health, Palmetto Health USC Medical Group, AnMed Health, and Spartanburg Regional Healthcare System for credentialing and recredentialing. • Express Scripts, Inc. for pharmacy services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				The process for delegated credentialing activities is defined in *Policy MCD-10, Credentialing Delegation*. A pre-delegation audit for proposed delegates is conducted to access a delegate's ability to credential providers in accordance with BlueChoice and SCDHHS criteria. The Credentialing Department conducts annual oversight of delegated entities to determine ongoing compliance and corrective action plans are required for identified deficiencies. Section 4 of *Policy MCD-10* addresses queries that are included in the verification process; however, it does not include the following queries SCDHHS Program Integrity requires: Suspended List and Behavioral Health Actions List. Evidence of annual oversight conducted within the last year was provided for all delegated entities. While the oversight reports were comprehensive and contained appropriate information, the credentialing and recredentialing oversight file review tool did not contain all queries SCDHHS Program Integrity requires. The Suspended List and the Behavioral Health Actions List were missing. *Quality Improvement Plan: Update Policy MCD-10, Credentialing Delegation and the credentialing and recredentialing oversight file review tools to include the following queries SCDHHS Program Integrity requires: Suspended List and Behavioral Health Actions List.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					As a required component of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, BlueChoice ensures pediatric immunization requirements are monitored by instructing providers to bill the vaccine codes for reporting purposes, as described on page 63 of the *Provider Manual*. The *2018 QM Program Annual Evaluation* reports Healthcare Effectiveness Data Information Set (HEDIS) childhood immunization rates and lists improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					The *Provider Manual* indicates BlueChoice follows the EPSDT periodicity schedule according to the American Academy of Pediatrics (AAP). EPSDT/Well-child services are indicated for members under 21; however, provider compliance with providing EPSDT services is monitored through random medical record documentation reviews and Gaps in Care, as described in *Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services* and noted in the *2018 QM Program Annual Evaluation*.
2. Core benefits provided by the MCO include all those specified by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			CCME identified uncorrected deficiencies from the previous EQR related to the following: •Incorrect grievance resolution timeframes documented in the Grievance Acknowledgement Letter and the "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" letter attachment •Incorrect grievance resolution timeframe documented in *Policy SC_GAXX_015, Grievance Process: Members* *Quality Improvement Plan: Ensure all deficiencies are addressed and corrections are implemented.*